DATED this 31st Day of August, 2015.

LSO Rules Analysis Memo

Italicized red text that is *double underscored* is new text that has been added to the pending rule.

THE FOLLOWING IS THE TEXT OF DOCKET NO. 16-0310-1501

011. DEFINITIONS: E THROUGH K.
For the purposes of these rules, the following terms are used as defined below: (3-19-07)

01. Educational Services. Services which are provided in buildings, rooms or areas designated or used as a school or as educational facilities; which are provided during the specific hours and time periods in which the educational instruction takes place in the normal school day and period of time for these students; and which are included in the individual educational plan for the participant or required by federal and state educational statutes or regulations; are not related services**;** and such services are provided to school age individuals as defined in Section 33-201, Idaho Code. (3-19-07)

02. Eligibility Rules. IDAPA 16.03.01, "Eligibility for Health Care Assistance for Families and Children," and IDAPA 16.03.05, "Rules Governing Eligibility for Aid to the Aged, Blind and Disabled (AABD)." (3-19-07)

03. Emergency Medical Condition. A medical condition manifesting itself by acute symptoms of sufficient severity, including severe pain, that a prudent lay person, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in the following: (3-19-07)

a. Placing the health of the individual, or, with respect to a pregnant woman, the health of the woman or unborn child, in serious jeopardy. (3-19-07)

b. Serious impairment to bodily functions. (3-19-07)

c. Serious dysfunction of any bodily organ or part. (3-19-07)

04. Enhanced Plan. The medical assistance benefits included under this chapter of rules. (3-19-07)

05. EPSDT. Early and Periodic Screening Diagnosis and Treatment. (3-19-07)

06. Equity. The net book value of all tangible and intangible assets less the recorded value of all liabilities, as recognized and measured in conformity with generally accepted accounting principles. (3-19-07)

07. Facility. Facility refers to a hospital, nursing facility, or an intermediate care facility for persons with intellectual disabilities. (3-19-07)

a. "Free-standing and Urban Hospital-based Behavioral Care Unit" means the same as Subsection 011.07.b. or 011.07.h. of this rule, and qualifies as a behavioral care unit nursing facility provider described in Section 266 of these rules. (4-4-13)

b. "Free-standing Nursing Facility" means a nursing facility that is not owned, managed, or operated

by, nor is otherwise a part of a licensed hospital. (3-19-07)

c. "Intermediate Care Facility for Persons with Intellectual Disabilities (ICF/ID)" means an entity as defined in Subsection 011.30 in this rule. (4-4-13)

d. "Nursing Facility (NF)" means a facility licensed as a nursing facility and federally certified to provide care to Medicaid and Medicare patients. (3-19-07)

e. "Rural Hospital-based Provider" means a hospital-based nursing facility not located within a metropolitan statistical area (MSA) as defined by the United States Bureau of the Census. (4-4-13)

f. "Rural Hospital-based Behavioral Care Unit" means the same as Subsection 011.07.e., and qualifies as a behavioral care unit nursing facility provider described in Section 266 of these rules. (4-4-13)

g. Skilled Nursing Facility" means a nursing facility licensed by the Department to provide twenty-four (24) hour skilled nursing services and federally certified as a "Nursing Facility" under Title XVIII. (3-19-07)

h. "Urban Hospital-based Nursing Facility" means a hospital-based nursing facility located within a metropolitan statistical area (MSA) as defined by the United States Bureau of the Census. (4-4-13)

08. Fiscal Intermediary Agency. An entity that provides services that allow the participant receiving personal assistance services, or his designee or legal representative, to choose the level of control he will assume in recruiting, selecting, managing, training, and dismissing his personal assistant regardless of who the employer of record is, and allows the participant control over the manner in which services are delivered. (5-8-09)

09. Fiscal Year. An accounting period that consists of twelve (12) consecutive months. (3-19-07)

10. Forced Sale. A forced sale is a sale required by a bankruptcy, foreclosure, the provisions of a will or estate settlement pursuant to the death of an owner, physical or mental incapacity of an owner which requires ownership transfer to existing partner or partners, or a sale required by the ruling of a federal agency or by a court order. (3-19-07)

11. Funded Depreciation. Amounts deposited or held which represent recognized depreciation. (3-19-07)

12. Generally Accepted Accounting Principles (GAAP). A widely accepted set of rules, conventions, standards, and procedures for reporting financial information as established by the Financial Standards Accounting Board. (3-19-07)

13. Goodwill. The amount paid by the purchaser that exceeds the value of the net tangible assets. The value of goodwill is derived from the economic benefits that a going concern may enjoy, as compared with a new one, from established relations in the related markets, with government departments and other noncommercial bodies and with personal relationships. These intangible assets cannot be separated from the business and sold as can plant and equipment. Under the theory that the excess payment would be made only if expected future earnings justified it, goodwill is often described as the price paid for excess future earnings. The amortization of goodwill is a nonallowable, nonreimbursable expense. (3-19-07)

14. Healthy Connections. The primary care case management model of managed care under Idaho Medicaid. (3-19-07)

15. Historical Cost. The actual cost incurred in acquiring and preparing an asset for use, including feasibility studies, architects' fees, and engineering studies. (3-19-07)

16. Home and Community Based Services (HCBS). HCBS are those long-term services and supports that assist eligible participants to remain in their home and community. ( )

167. ICF/ID Living Unit. The physical structure that an ICF/ID uses to house patients. (3-19-07)

1~~7~~8. Improvements. Improvements to assets which increase their utility or alter their use. (3-19-07)

1~~8~~9. Indirect Care Costs. The following costs either directly coded to the nursing facility or allocated to the nursing facility through the Medicare step-down process described in the PRM: (3-19-07)

a. Activities; (3-19-07)

b. Administrative and general care costs; (3-19-07)

c. Central service and supplies; (3-19-07)

d. Dietary (non-"raw food" costs); (3-19-07)

e. Employee benefits associated with the indirect salaries; (3-19-07)

f. Housekeeping; (3-19-07)

g. Laundry and linen; (3-19-07)

h. Medical records; (3-19-07)

i. Other costs not included in direct care costs, or costs exempt from cost limits; and (3-19-07)

j. Plant operations and maintenance (excluding utilities). (3-19-07)

~~19~~20. Inflation Adjustment. The cost used in establishing a nursing facility's prospective reimbursement rate is indexed forward from the midpoint of the cost report period to the midpoint of the rate year using the inflation factor plus one percent (+1%) per annum. (3-19-07)

2~~0~~1. Inflation Factor. For use in establishing nursing facility prospective rates, the inflation factor is the Skilled Nursing Facility Market Basket as established by Data Resources, Inc. (DRI), or its successor. If subsequent to the effective date of these rules, Data Resources, Inc., or its successor develops an Idaho-specific nursing facility index, it will be used. The Department is under no obligation to enter into an agreement with DRI or its successor to have an Idaho-specific index established. The national index is used when there is no state or regional index. (3-19-07)

2~~1~~2. In-State Care. Medical services provided within the Idaho border or in counties bordering Idaho are considered to be in-state, excluding long term care. (3-19-07)

2~~2~~3. Inspection of Care Team (IOCT). An interdisciplinary team which provides inspection of care in intermediate care facilities for persons with intellectual disabilities approved by the Department as providers of care for eligible medical assistance participants. Such a team is composed of: (3-19-07)

a. At least one (1) registered nurse; and (3-19-07)

b. One (1) Qualified Intellectual Disabilities Professional (QIDP); and when required, one (1) of the following: (3-19-07)

i. A consultant physician; or (3-19-07)

ii. A consultant social worker; or (3-19-07)

iii. When appropriate, other health and human services personnel responsible to the Department as employees or consultants. (3-19-07)

2~~3~~4. Instrumental Activities of Daily Living (IADL). Those activities performed in supporting the

activities of daily living, including, but not limited, to managing money, preparing meals, shopping, light housekeeping, using the telephone, or getting around in the community. (3-19-07)

2~~4~~5. Interest. The cost incurred for the use of borrowed funds. (3-19-07)

2~~5~~6. Interest on Capital Indebtedness. The cost incurred for borrowing funds used for acquisitions of capital assets, improvements, etc. These costs are reported under property costs. (3-19-07)

2~~6~~7. Interest on Working Capital. The costs incurred for borrowing funds which will be used for "working capital" purposes. These costs are reported under administrative costs. (3-19-07)

2~~7~~8. Interest Rate Limitation. The interest rate allowed for working capital loans and for loans for major movable equipment for ICF/ID facilities is the prime rate as published in the western edition of the Wall Street Journal or successor publication, plus one percent (+1%) at the date the loan is made. (3-19-07)

2~~8~~9. Interim Reimbursement Rate (IRR). A rate paid for each Medicaid patient day which is intended to result in total Medicaid payments approximating the amount paid at audit settlement. The interim reimbursement rate is intended to include any payments allowed in excess of the percentile cap. (3-19-07)

~~29~~30. Intermediary. Any organization that administers the Title XIX and Title XXI program; in this case the Department of Health and Welfare. (3-19-07)

3~~0~~1. Intermediate Care Facility for Persons with Intellectual Disabilities (ICF/ID). An entity licensed as an ICF/ID and federally certified to provide care to Medicaid and Medicare participants with developmental disabilities. (3-19-07)

3~~1~~2. Keyman Insurance. Insurance on owners or employees with extraordinary talents in which the direct or indirect beneficiary is the facility or its owners. Premiums related to keyman insurance are not allowable. (3-19-07)

(BREAK IN CONTINUITY OF SECTIONS)

075. ENHANCED PLAN BENEFITS: COVERED SERVICES.
Individuals who are eligible for the Medicaid Enhanced Plan Benefits are eligible for all benefits covered under IDAPA 16.03.09, "Medicaid Basic Plan Benefits." In addition to those benefits, individuals in the enhanced plan are eligible for the following enhanced benefits as provided for in this chapter of rules. (4-11-15)

01. Dental Services. Dental Services are provided as described under Sections 080 through 089 of these rules. (3-29-12)

02. Enhanced Hospital Benefits. Organ transplants are provided under the Enhanced Hospital services as described in Sections 090 through 099 of these rules. (3-19-07)

03. Enhanced Outpatient Behavioral Health Benefits. Enhanced Outpatient Behavioral Health services are described in IDAPA 16.03.09, "Medicaid Basic Plan Benefits." (3-20-14)

04. Enhanced Home Health Benefits. Private Duty Nursing services are provided under the Enhanced Home Health as described in Sections 200-219 of these rules. (3-19-07)

05. Therapies. Physical, Speech, and Occupational Therapy Providers as described in Section 215 of these rules. (3-19-07)

06. Long Term Care Services. The following services are provided under the Long Term Care Services. (3-30-07)

a. Nursing Facility Services as described in Sections 220 through 299 of these rules. (3-19-07)

b. Personal Care Services as described in Sections 300 through 308 of these rules. (3-30-07)

c. A & D Wavier Services as described in Sections 320 through 330 of these rules. (3-30-07)

07. Hospice. Hospice services as described in Sections 450 through 459 of these rules. (3-19-07)

08. Developmental Disabilities Services. (3-19-07)

~~*a. Developmental Disability Standards as described in Sections 500 through 506 of these rules.* (3-19-07)~~

~~*b.*~~**a.** Children's Developmental Disability Services as described in Sections 520 through 528, 660 through 666, and 680 through 686 of these rules. (7-1-13)

~~*c.*~~**b.** Adult Developmental Disabilities Services as described in Sections 5~~*20*~~*19*, ~~*and*~~ 64~~*95*~~ through 657*, and 700 through 706* of these rules. ~~*(7-1-13)*~~*( )*

~~*d.*~~**c.** ICF/ID as described in Sections 580 through 649 of these rules. (3-19-07)

~~*e. Developmental Disabilities Agencies as described in Sections 700 through 719 of these rules.* (3-19-07)~~

09. Service Coordination Services. Service coordination as described in 720 through 779 of these rules. (3-19-07)

10. Breast and Cervical Cancer Program. Breast and Cervical Cancer Program is described in Sections 780 through 800 of these rules. (3-19-07)

(BREAK IN CONTINUITY OF SECTIONS)

302. PERSONAL CARE SERVICES: ELIGIBILITY.

01. Financial Eligibility. The participant must be financially eligible for medical assistance under IDAPA 16.03.01, "Eligibility for Health Care Assistance for Families and Children," or 16.03.05, "Rules Governing Eligibility for Aid to the Aged, Blind and Disabled (AABD)." (3-19-07)

02. Other Eligibility Requirements. Regional Medicaid Services (RMS) will prior authorize payment for the amount and duration of all services when all of the following conditions are met: (3-19-07)

a. The RMS finds that the participant is capable of being maintained safely and effectively in his own home or personal residence using PCS. (3-19-07)

b. The participant is an adult for whom a Uniform Assessment Instrument (UAI) has been completed, or a child for whom a children's PCS assessment has been completed; (3-29-10)

c. The RMS reviews the documentation for medical necessity; and (4-2-08)

d. The participant has a plan of care that meets the person-centered planning requirements described in Sections 316 and 317 of these rules. ~~*(4-2-08)*~~*( )*

03. State Plan Option. A participant who receives medical assistance is eligible for PCS under the State Medicaid Plan option if the Department finds he requires PCS due to a medical condition that impairs his physical or mental function or independence. (3-19-07)

04. Annual Eligibility Redetermination. The participant's eligibility for PCS must be redetermined at least annually under Subsections 302.01. through 302.03 of these rules. (3-19-07)

a. The annual financial eligibility redetermination must be conducted under IDAPA 16.03.01, "Eligibility for Health Care Assistance for Families and Children," or 16.03.05, "Rules Governing Eligibility for Aid to the Aged, Blind and Disabled (AABD)." RMS must make the medical eligibility redetermination. The redetermination can be completed more often than once each year at the request of the participant, the Self-Reliance Specialist, the Personal Assistance Agency, the personal assistant, the supervising RN, the QIDP, or the physician. (4-2-08)

b. The medical redetermination must assess the following factors: (3-19-07)

i. The participant's continued need for PCS; (3-19-07)

ii. Discharge from PCS; and (3-19-07)

iii. Referral of the participant from PCS to a nursing facility. (3-19-07)

(BREAK IN CONTINUITY OF SECTIONS)

304. PERSONAL CARE SERVICES: PROCEDURAL REQUIREMENTS.

01. Service Delivery Based on Plan of Care or NSA. All PCS services are provided based on a written plan of care or a negotiated service agreement (NSA). The requirements for the NSA for participants in Residential Care or Assisted Living Facilities are described in IDAPA 16.03.22, "Residential Care or Assisted Living Facilities in Idaho." The requirements for the NSA for participants in Certified Family Homes are described in IDAPA 16.03.19, "Rules Governing Certified Family Homes." The Personal Assistance Agency and the participant who lives in his own home are responsible to prepare the plan of care. (3-19-07)

a. The plan of care for participants who live in their own homes or in a PCS Family Alternate Care Home is based on: (3-29-10)

i. The physician's or authorized provider's information if applicable; (4-2-08)

ii. The results of the UAI for adults, the children's PCS assessment and, if applicable, the QIDP's assessment and observations of the participant; and (3-29-10)

iii. Information obtained from the participant. (3-19-07)

b. The plan of care must include all aspects of medical and non-medical care that the provider needs to perform, including the amount, type and frequency of necessary services. (3-19-07)

c. The plan of care must be revised and updated based upon treatment results or a change(s) in the participant's needs, or both, but at least annually. (3-19-07)

d. The plan of care or NSA must meet the person-centered planning requirements described in Sections 316 and 317 of these rules. *( )*

02. Service Supervision. The delivery of PCS may be overseen by a licensed professional nurse (RN) or Qualified Intellectual Disabilities Professional (QIDP). The RMS must identify the need for supervision.(3-19-07)

a. Oversight must include all of the following: (3-19-07)

i. Assistance in the development of the written plan of care; (3-19-07)

ii. Review of the treatment given by the personal assistant through a review of the participant's PCS record as maintained by the provider; (3-19-07)

iii. Reevaluation of the plan of care as necessary; and (3-19-07)

iv. Immediate notification of the guardian, emergency contact, or family members of any significant changes in the participant's physical condition or response to the services delivered. (3-19-07)

b. All participants who are developmentally disabled, other than those with only a physical disability as determined by the RMS, may receive oversight by a QIDP as defined in 42 CFR 483.430. Oversight must include: (3-19-07)

i. Assistance in the development of the plan of care for those aspects of active treatment which are provided in the participant's personal residence by the personal assistant; (3-19-07)

ii. Review of the care or training programs given by the personal assistant through a review of the participant's PCS record as maintained by the provider and through on-site interviews with the participant; (3-19-07)

iii. Reevaluation of the plan of care as necessary, but at least annually; and (3-19-07)

iv. An on-site visit to the participant to evaluate any change of condition when requested by the personal assistant, the Personal Assistance Agency, the nurse supervisor, the service coordinator or the participant. (3-19-07)

03. Prior Authorization Requirements. All PCS services must be prior authorized by the Department. Authorizations will be based on the information from: (3-29-10)

a. The children's PCS assessment or Uniform Assessment Instrument (UAI) for adults; (3-29-10)

b. The individual service plan developed by the Personal Assistance Agency; and (3-29-10)

c. Any other medical information that supports the medical need. (3-29-10)

04. PCS Record Requirements for a Participant in His Own Home. The PCS records must be maintained on all participants who receive PCS in their own homes or in a PCS Family Alternate Care Home. (3-29-10)

a. Written Requirements. The PCS provider must maintain written documentation of every visit made to the participant's home and must record the following minimum information: (3-19-07)

i. Date and time of visit; (3-19-07)

ii. Length of visit; (3-19-07)

iii. Services provided during the visit; and (3-19-07)

iv. Documentation of any changes noted in the participant's condition or any deviations from the plan of care. (3-19-07)

b. Participant's Signature. The participant must sign the record of service delivery verifying that the services were delivered. The RMS may waive this requirement if it determines the participant is not able to verify the service delivery. (3-19-07)

c. Provider Signature. The Plan of Care must be signed by the provider indicating that they will deliver services according to the authorized service plan and consistent with home and community based requirements. ( )

~~e~~d. Copy Requirement. A copy of the information required in Subsection 304.04 of these rules must be maintained in the participant's home unless the RMS authorizes the information to be kept elsewhere. Failure to maintain this information may result in recovery of funds paid for undocumented services. ~~(3-19-07)~~( )

~~d~~e. Telephone Tracking System. Agencies may employ a software system that allows personal assistants to register their start and stop times and a list of services by placing a telephone call to the agency system from the participant's home. This system will not take the place of documentation requirements of Subsection 304.04 of these rules. (3-19-07)

~~c. Participant in a Residential or Assisted Living Facility. The PCS record requirements for participants in Residential Care or Assisted Living Facilities are described in IDAPA 16.03.22, "Residential Care or Assisted Living Facilities in Idaho." (3-19-07)~~

~~f. Participant in a Certified Family Home. The PCs record requirements for participants in Certified Family Homes are described in IDAPA 16.03.19, "Rules Governing Certified Family Homes." (3-19-07)~~

05. PCS Record Requirements for a Participant in a Residential Care or Assisted Living Facility or Certified Family Home. *The PCS records must be maintained on all participants who receive PCS in a Residential Care or Assisted Living Facility or Certified Family Home.* ( )

a. *Participant in a Residential Care or Assisted Living Facility. The additional PCS record requirements for participants in Residential Care or Assisted Living Facilities are described in IDAPA 16.03.22, "Residential Care or Assisted Living Facilities in Idaho."* ( )

b. *Participant in a Certified Family Home. The additional PCS record requirements for participants in Certified Family Homes are described in IDAPA 16.03.19, "Rules Governing Certified Family Homes."* ( )

c. *Participant's Signature. The participant or legal guardian must sign the NSA agreeing to the delivery of services as specified.* ( )

d. *Provider Signature. The NSA must be signed by the supervisory nurse or agency personnel responsible for developing the NSA with the participant, and must indicate that they will deliver services according to the authorized NSA and consistent with home and community-based requirements.* ( )

0~~5~~6. **Provider Responsibility for Notification**. The Personal Assistance Agency is responsible to notify the RMS and physician or authorized provider when any significant changes in the participant's condition are noted during service delivery. This notification must be documented in the Personal Assistance Agency record. (3-19-07)

(BREAK IN CONTINUITY OF SECTIONS)

308. PERSONAL CARE SERVICES (PCS): QUALITY ASSURANCE.

01. Responsibility for Quality. Personal Assistance Agencies, *Residential Care or Assisted Living Facilities, and Certified Family Homes furnishing PCS* are responsible for assuring that they provide quality services in compliance with applicable rules. ~~(3-19-07)~~( )

02. Review Results. Results of quality assurance reviews conducted by the Department must be transmitted to the provider within forty-five (45) days after the review is completed. (3-19-07)

03. Quality Improvement Plan. The provider must respond within forty-five (45) days after the results are received. If problems are identified, the provider must implement a quality improvement plan and report

the results to the Department upon request. (3-19-07)

04. HCBS Compliance. Personal Assistance Agencies *are responsible for ensuring they meet the setting requirements described in Section 313 of these rules*. Residential Care or Assisted Living Facilities, and Certified Family Homes are responsible for ensuring that they meet the setting requirements described in Sections 313 *and* 314 of these rules. *All providers furnishing PCS are responsible for ensuring they meet the person-centered planning requirements described in Sections 316 through 317 of these rules. PCS providers* must comply with associated Department *quality* assurance activities. The Department may take enforcement actions as described in IDAPA 16.03.09, "Medicaid Basic Plan Benefits," Section 205, if the provider fails to comply with any term or provision of the provider agreement, or any applicable state or federal regulation. ( )

309. (RESERVED)

SUB AREA: HOME AND COMMUNITY BASED SERVICES
(Sections 310 - 317)

310. HOME AND COMMUNITY BASED SERVICES.
Home and Community Based Services (HCBS) are those long-term services and supports that assist eligible participants to remain in their home and community. The federal authorities under 42 CFR 441.301, 42 CFR 441.710, and 42 CFR 441.725 require the state to deliver HCBS in accordance with the rules described in Sections 310 through 318 of these rules. HCBS include the following: ( )

01. Children's Developmental Disability Services. Children's developmental disability services as defined in Sections 663 and 683 of these rules. ( )

02. Adult Developmental Disability Services. Adult developmental disability services as defined in Sections 645 through 659, 703, and 705 of these rules. ( )

03. Consumer-Directed Services. Consumer-directed services as defined in IDAPA 16.03.13, "Consumer-Directed Services." ( )

04. Aged and Disabled Waiver Services. Aged and disabled waiver services as defined in Section 326 of these rules. ( )

05. Personal Care Services. Personal care services as defined in Section 303 of these rules. ( )

311. HCBS REQUIREMENTS AND DECISION-MAKING AUTHORITY.
HCBS requirements, contained in Sections 312 through Sections 317 of these rules, do not supersede decision-making authority legally assigned to another individual or entity on the participant's behalf. This includes: ( )

***01. Payee**. A representative payee appointed by the Social Security Administration;* ( )

***02. Restrictions (Probation or Parole)**. Court-imposed restrictions related to probation or parole;* ( )

***03. Restrictions (When Committed)**. Court-imposed restrictions when committed to the Director of Health and Welfare; and* ( )

***04. Legal Guardians Who Retain Full Decision-making Authority**. It is presumed that the parent or parents of participants birth through seventeen (17) years of age have full decision-making authority unless the minor child has another legally assigned decision-making authority.* ( )

312. HOME AND COMMUNITY BASED SETTINGS.
Home and community based settings include all locations where participants who receive HCBS live or receive their

services. ( )

01. Home and Community Based Settings Not Included. Home and community based settings do not include the following: ( )

a. A nursing facility; ( )

b. An institution for mental diseases; ( )

c. An intermediate care facility for persons with intellectual disabilities (ICF/ID); ( )

d. A hospital; or ( )

e. Any other location that has the qualities of an institutional setting. These institutional qualities include: ( )

i. Any setting that is located in a building that is also a publicly or privately operated facility that provides inpatient institutional treatment; or ( )

ii. A building on the grounds of, or immediately adjacent to, a state or federally operated inpatient treatment facility; or ( )

iii. Any setting that has the effect of isolating participants receiving Medicaid HCBS from the broader community of individuals not receiving Medicaid HCBS. ( )

313. *REQUIRED* HOME AND COMMUNITY BASED *QUALITIES*.
Home and community based settings must support eligible participants to have the same opportunities for integration, independence, choice, and rights as individuals who do not require supports or services to remain in their home or community. *If a setting requirement described in this rule presents a health or safety risk to the participant or those around the participant, goals must be identified with strategies to mitigate the risk. These goals and strategies must be documented in the person-centered plan.* Providers must develop and implement policies and procedures to address *the following* HCBS setting requirements. ( )

01. *Required* Home and Community Based *Qualities*. Home and community based settings are required to have the following qualities: ( )

a. Integration and Access. The setting is integrated in and supports full access *to the greater community for* participants receiving HCBS. Typical, age-appropriate activities include opportunities to seek employment and work in competitive integrated settings, engage in community life, control personal resources, and receive services in the community in the same manner as individuals who do not require supports or services to remain in their home or community. ( )

b. Selection of Setting. Home and community based settings are selected by the participant or *the participant's decision-making authority* from among *disability-specific and non-disability-specific* settings, and are based on the participant *'s* needs and preferences *including* consideration of the participant's safety and the safety of those around the participant. ( )

c. Participant Rights. The setting ensures a participant's rights of privacy, dignity, and respect, and freedom from coercion and unauthorized restraint *are honored*. ( )

d. Autonomy and Independence. The setting optimizes, but does not regiment, *an* individual *'s* initiative, autonomy, and independence in making life choices, including daily activities, physical environment, and with whom to interact. ( )

e. Choice. The setting *promotes* opportunities for participant choice regarding the services and supports provided in the setting. ( )

02. **Services Delivered in the Participant's Own Home**. It is presumed that services delivered in the participant's own home, that is not a provider-owned or controlled residence, meet the HCBS setting requirements described in this rule. Providers may not impose restrictions on HCBS setting qualities in a participant's own home without *goals and strategies to mitigate risk described in this rule* that *have* been agreed to through the person-centered planning process. ( )

314. RESIDENTIAL PROVIDER-OWNED OR CONTROLLED SETTING QUALITIES.
In addition to the setting *requirements* described in Section 313 of these rules, provider-owned or controlled settings, including Residential Care or Assisted Living Facilities and Certified Family Homes that provide services to HCBS participants, must also meet the following conditions: ( )

01. **Written Agreement**. A lease, residency agreement, admission agreement, or other form of written agreement will be in place for each HCBS participant at the time of occupancy. The lease or residency agreement must provide protections that address eviction processes and appeals comparable to those provided under Idaho landlord tenant law. ( )

02. **Privacy**. Participants have the right to privacy within their residence. Each participant must have privacy in their sleeping or living unit to include the following: ( )

a. The right to entrance doors which are lockable by the individual, with only appropriate staff having keys to doors. ( )

b. Participants sharing units have a choice of roommates in that setting. ( )

03. **Décor**. Participants have the freedom to furnish and decorate their sleeping or living units within the lease or other agreement. ( )

04. **Schedules and Activities**. Participants have the freedom and support to control their own schedules and activities. ( )

05. **Access To Food**. Participants have access to food at any time. ( )

06. **Visitors**. Participants are able to have visitors of their choosing at any time *in accordance with the applicable requirements under IDAPA 16.03.19, "Rules Governing Certified Family Homes," and IDAPA 16.03.22, "Residential Care or Assisted Living Facilities in Idaho."*. ( )

07. **Accessibility**. The setting is physically accessible to the participant. ( )

315. EXCEPTIONS TO RESIDENTIAL PROVIDER-OWNED OR CONTROLLED SETTING QUALITIES.
Exceptions to residential setting requirements outlined in Section 314 of these rules must be made based on the needs of the participant that are identified through person-centered planning. Service plans with exceptions to residential setting requirements must be submitted to the Department or its designee for review and approval. When an exception is made, the following information must be documented in the person-centered service plan: ( )

01. **Assessed Needs**. Specific and individualized assessed needs that are related to the exception. ( )

02. **Interventions and Supports**. Positive interventions and supports used prior to any exceptions to the person-centered service plan. ( )

03. **Prior Methods**. List less intrusive methods previously implemented that were unsuccessful in addressing the needs of the participant. ( )

04. **Description of Intervention**. A clear description of the intervention for the exception that is directly proportionate to the specific assessed needs. ( )

05. Data Collection. Regular collection and review of data to measure the ongoing effectiveness of the exception. ( )

06. Time Limits. Established time limits for periodic reviews to determine if the exception is still necessary, if a transition plan can be developed, or if the exception can be terminated. ( )

07. Informed Consent. Informed consent of the participant or legal guardian for the exception. ( )

08. Assurance of No Harm. An assurance that interventions and supports will cause no harm to the participant. ( )

316. HOME AND COMMUNITY BASED PERSON-CENTERED PLANNING REQUIREMENTS. All participants *or their decision-making authority* must direct the development of their service plan through a person-centered planning process. Information and support must be given to the HCBS participant to maximize their ability to make informed choices and decisions. Individuals invited to participate in the person-centered planning process should be identified by the participant or *the participant's decision-making authority. Legal guardians who do not have full decision-making authority as described in Section 311 of these rules* will have a participatory role as needed and defined by the participant. The person-centered planning process must: *( )*

01. Timely and Convenient. Be *conducted* timely and occur at *convenient* times and locations to the participant *and the participant's decision-making authority in accordance with program requirements*. *( )*

02. Cultural Considerations. Reflect cultural considerations of the participant. ( )

03. In Plain Language and Accessible. Be conducted by providing information in plain language and in a manner that is accessible to participants with disabilities and persons who are limited English proficient as defined in 42 CFR 435.905(b). ( )

04. Conflict Resolution. Utilize strategies for solving conflict or disagreement within the process, and follow clear conflict-of-interest guidelines for all planning participants. ( )

317. HOME AND COMMUNITY BASED PERSON-CENTERED SERVICE PLAN REQUIREMENTS. All person-centered service plans must reflect the following components: *( )*

01. Services And Supports. Clinical services and supports that are important for the participant's behavioral, functional, and medical needs as identified through an assessment. ( )

02. Service Delivery Preferences. Indication of what is important to the participant with regard to the service provider and preferences for the delivery of such services and supports. ( )

03. Setting Selection. HCBS settings selected by the participant *or the participant's decision-making authority* are chosen from among a variety of setting options, *as required in Section 313 of these rules*. The person-centered service plan must identify and document the alternative home and community setting options that were considered by the participant, *or the participant's decision-making authority*. *( )*

04. Participant Strengths and Preferences. ( )

05. Individually Identified Goals and Desired Outcomes. ( )

06. Paid and Unpaid Services and Supports. Paid and unpaid services and supports that will assist the participant to achieve identified goals, and the providers of those services and supports, including natural supports. ( )

07. Risk Factors. Risk factors to the participant as well as people around the participant and measures in place to minimize them, including individualized back-up plans and strategies when needed. ( )

08. Understandable Language. Be understandable to the participant receiving services and supports,

and the individuals important in supporting him or her. At a minimum, the written plan must be understandable, and written in plain language in a manner that is accessible to participants with disabilities and persons who are limited English proficient, consistent with 42 CFR 435.905(b). ( )

09. Plan Monitor. Identify the name of the individual or entity responsible for monitoring the plan. ( )

10. Plan Signatures. Be finalized and agreed to, *by the participant, or the participant's decision-making authority, in writing, indicating* informed consent. *The plan must also be* signed by all individuals and providers responsible for its implementation *indicating they will deliver services according to the authorized plan of service and consistent with home and community based requirements*. ( )

a. Children's DD service providers responsible for implementation of the plan include *the providers of those services defined* in Sections 66*3* and 68*3* of these rules. ( )

b. Adult DD service providers responsible for implementation of the plan include those required to develop a provider implementation plan as defined in Sections 513 and 654 of these rules. ( )

c. Consumer-directed service providers responsible for implementation of the plan include the participant, Support Broker, and Fiscal Employment Agency as identified in IDAPA 16.03.13, "Consumer-Directed Services." ( )

d. Personal Care and Aged and Disabled Waiver service providers responsible for the implementation of the plan include the providers of those services defined in Sections 30*3* and 32*6* of these rules. ( )

11. Plan Distribution. Be distributed to the participant *and the participant's decision-making authority, if applicable*, and other people involved in the implementation of the plan. At a minimum, the following providers will receive a copy of the plan: ( )

a. Children's DD providers *of services* defined in Sections 66*3* and 68*3* of these rules as identified on the plan of service developed by the family-centered planning team. ( )

b. Adult DD service providers required to develop a provider implementation plan as defined in Sections 513 and 654 of these rules. Additionally, the participant will determine during the person-centered planning process whether the service plan, in whole or in part, will be distributed to any other developmental disability service provider. ( )

c. Consumer-Directed service providers as defined in IDAPA 16.03.13, "Consumer-Directed Services," Section 110. *A*dditio*nally*, the participant*, or the participant's decision-making authority* will determine during the person-centered planning process whether the service plan, in whole or in part, *will* be distributed to any other community support worker or vendors. ( )

d. Personal Care and Aged and Disabled Waiver service providers *furnishing those services* defined in Sections 30*3* and 32*6* of these rules. ( )

12. Residential Requirements. For participants living in residential provider owned or controlled settings as described in Section 31*4* of these rules, the following additional requirements apply: ( )

a. Options described in Subsection 317.03 of this rule must include a residential setting option that allows for private units. Selection of residential settings will be based on the participant's needs, preferences, and resources available for room and board. ( )

b. Any exception to residential provider owned or controlled setting qualities as described in Section 31*4* of these rules must be documented in the person-centered plan as described in Section 31*5* of these rules. ( )

31*8*. HCBS TRANSITION PLAN.

As required by the Department, all current providers of HCBS must complete a Department-approved self assessment form related to the setting requirements and qualities described in Sections 311 through 314 of these rules. ( )

01. Provider Transition Plan. *As part of the self-assessment process, p*roviders not in compliance with any portion of the new requirements and qualities must *develop* a plan for coming into compliance. *Self-assessment forms are subject to review and validation by the Department via quality assurance activities.* ( )

02. New HCBS Providers or Service Settings. New HCBS providers or service settings are expected to fully comply with the HCBS requirements and qualities as a condition of becoming a Medicaid provider. ( )

03. Quality Assurance. The Department will begin enforcement of quality assurance compliance with Sections 311 through 314 of these rules on January 1, 2017. ( )

~~*309.*~~ **319. (RESERVED)**

(BREAK IN CONTINUITY OF SECTIONS)

328. AGED AND DISABLED WAIVER SERVICES: PROCEDURAL REQUIREMENTS.

01. Role of the Department. The Department or its contractor will provide for the administration of the UAI, and the development of the initial individual service plan. This will be done either by Department staff or a contractor. The Department or its contractor will review and approve all individual service plans, and will authorize Medicaid payment by type, scope, and amount. (4-4-13)

a. Services that are not in the individual service plan approved by the Department or its contractor are not eligible for Medicaid payment. (4-4-13)

b. Services in excess of those in the approved individual service plan are not eligible for Medicaid payment. (3-19-07)

c. The earliest date that services may be approved by the Department or its contractor for Medicaid payment is the date that the participant's individual service plan is signed by the participant or his designee. (4-4-13)

02. Pre-Authorization Requirements. All waiver services must be pre-authorized by the Department. Authorization will be based on the information from: (3-19-07)

a. The UAI; (3-19-07)

b. The individual service plan developed by the Department or its contractor; and (3-19-07)

c. Any other medical information which verifies the need for nursing facility services in the absence of the waiver services. (3-19-07)

03. UAI Administration. The UAI will be administered, and the initial individual service plan developed, by the Department or its contractor. (4-4-13)

04. Individual Service Plan. All waiver services must be authorized by the Department or its contractor in the Region where the participant will be residing and services provided based on a written individual service plan. (4-4-13)

a. The initial individual service plan is developed by the Department or its contractor, based on the UAI, in conjunction with: (4-4-13)

i. The waiver participant (with efforts made by the Department or its contractor to maximize the participant's involvement in the planning process by providing him with information and education regarding his

rights); (4-4-13)

ii. The guardian, when appropriate; (3-30-07)

iii. The supervising nurse or case manager, when appropriate; and (3-19-07)

iv. Others identified by the waiver participant. (3-19-07)

b. The individual service plan must include the following: (3-19-07)

i. The specific type, amount, frequency, and duration of Medicaid reimbursed waiver services to be provided; (3-30-07)

ii. Supports and service needs that are to be met by the participant's family, friends, neighbors, volunteers, church, and other community services; (3-30-07)

iii. The providers of waiver services when known; (3-30-07)

iv. Documentation that the participant has been given a choice between waiver services and institutional placement; and (3-19-07)

v. The signature of the participant or his legal representative, agreeing to the plan. (3-19-07)

c. The individual service plan must be revised and updated at least annually, based upon treatment results or a change in the participant's needs. (3-19-07)

d. All services reimbursed under the Aged and Disabled Waiver must be authorized by the Department or its contractor prior to the payment of services. (4-4-13)

e. The individual service plan, which includes all waiver services, is monitored by the Personal Assistance Agency, participant, family, and the Department or its contractor. (4-4-13)

05. Service Delivered Following a Written Plan of Care. All services that are provided must be based on a written plan of care. (3-30-07)

a. The plan of care is developed by the plan of care team which includes: (3-30-07)

i. The waiver participant with efforts made to maximize his participation on the team by providing him with information and education regarding his rights; (3-30-07)

~~*ii. The Department's administrative case manager;* (3-30-07)~~

~~i~~ii. The guardian when appropriate; (3-30-07)

i~~v~~ii. Service provider identified by the participant or guardian; and (3-30-07)

iv. May include others identified by the waiver participant. (3-30-07)

b. The plan of care must be based on an assessment process approved by the Department. (3-30-07)

c. The plan of care must include the following: (3-30-07)

i. The specific types, amounts, frequency and duration of Medicaid reimbursed waiver services to be provided; (3-30-07)

ii. Supports and service needs that are to be met by the participant's family, friends and other community services; (3-30-07)

iii. The providers of waiver services; (3-30-07)

iv. Goals to be addressed within the plan year; (3-30-07)

v. Activities to promote progress, maintain functional skills, or delay or prevent regression; and (3-30-07)

vi. The signature of the participant or his legal representative. (3-30-07)

vii. The signature of the agency or provider indicating that they will deliver services according to the authorized service plan and consistent with home and community based requirements. *( )*

d. The plan must be revised and updated by the plan of care team based upon treatment results or a change in the participant's needs. A new plan must be developed and approved annually. (3-30-07)

e. The Department's ~~*case manager*~~ *Nurse Reviewer* monitors the plan of care and all waiver services. ~~*(3-30-07)*~~*( )*

f. The plan of care may be adjusted during the year with an addendum to the plan. These adjustments must be based on changes in a participant's need or demonstrated outcomes. Additional assessments or information may be clinically necessary. Adjustment of the plan of care is subject to prior authorization by the Department. (3-30-07)

06. Individual Service Plan and Written Plan of Care. The development and documentation of the individual service plan and written plan of care must meet the person-centered planning requirements described in Sections 316 and 317 of these rules. *( )*

0~~6~~7. Provider Records. Records will be maintained on each waiver participant. (3-19-07)

a. Each service provider must document each visit made or service provided to the participant, and will record at a minimum the following information: (3-19-07)

i. Date and time of visit; (3-19-07)

ii. Services provided during the visit; (3-19-07)

iii. Provider observation of the participant's response to the service, if appropriate to the service provided, including any changes in the participant's condition; and (3-19-07)

iv. Length of visit, including time in and time out, if appropriate to the service provided. Unless the Department or its contractor determines that the participant is unable to do so, the service delivery will be verified by the participant as evidenced by their signature on the service record. (4-4-13)

b. The provider is required to keep the original service delivery record. A copy of the service delivery record will be maintained in the participant's living arrangement unless authorized to be kept elsewhere by the Department. Failure to maintain documentation according to these rules will result in the recoupment of funds paid for undocumented services. (4-4-13)

c. The individual service plan initiated by the Department or its contractor must specify which waiver services are required by the participant. The plan will contain all elements required by Subsection 328.04.a. of these rules and a copy of the most current individual service plan will be maintained in the participant's home and will be available to all service providers and the Department. A copy of the current individual service plan and UAI will be available from the Department or its contractor to each individual service provider with a release of information signed by the participant or legal representative. (4-4-13)

d. Record requirements for participants in residential care or assisted living facilities are described in

IDAPA 16.03.22, "Residential Care or Assisted Living Facilities in Idaho." (4-4-13)

e. Record requirements for participants in certified family homes are described in IDAPA 16.03.19, "Rules Governing Certified Family Homes." (4-4-13)

0~~7~~8. Provider Responsibility for Notification. The service provider is responsible to notify the Department or its contractor, physician or authorized provider, or case manager, and family if applicable, when any significant changes in the participant's condition are noted during service delivery. Such notification will be documented in the service record. (4-4-13)

0~~8~~9. Records Retention. Personal Assistance Agencies, and other providers are responsible to retain their records for five (5) years following the date of service. (3-19-07)

10~~9~~. Requirements for an Fiscal Intermediary (FI). Participants of PCS will have one (1) year from the date which services begin in their geographic region to obtain the services of an FI and become an employee in fact or to use the services of an agency. Provider qualifications are in accordance with Section 329 of these rules. (3-19-07)

329. AGED AND DISABLED WAIVER SERVICES: PROVIDER QUALIFICATIONS AND DUTIES. Each provider must have a signed provider agreement with the Department for each of the services it provides. (3-19-07)

01. Employment Status. Unless otherwise specified by the Department, each individual service provider must be an employee of record or fact of an agency. The Department may enter into provider agreements with individuals in situations in which no agency exists, or no fiscal intermediary agency is willing to provide services. Such agreements will be reviewed annually to verify whether coverage by a personal assistance agency or fiscal intermediary agency is still not available. (5-8-09)

02. Fiscal Intermediary Services. An agency that has responsibility for the following: (5-8-09)

a. To directly assure compliance with legal requirements related to employment of waiver service providers; (3-19-07)

b. To offer supportive services to enable participants or families consumers to perform the required employer tasks themselves; (3-19-07)

c. To bill the Medicaid program for services approved and authorized by the Department; (3-19-07)

d. To collect any participant participation due; (3-19-07)

e. To pay personal assistants and other waiver service providers for service; (3-19-07)

f. To perform all necessary withholding as required by state and federal labor and tax laws, rules and regulations; (3-19-07)

g. To assure that personal assistants providing services meet the standards and qualifications under in this rule; (5-8-09)

h. To maintain liability insurance coverage; (5-8-09)

i. To conduct, at least annually, participant satisfaction or quality control reviews that are available to the Department and the general public; (5-8-09)

j. To obtain such criminal background checks and health screens on new and existing employees of record and fact as required. (5-8-09)

03. Provider Qualifications. All providers of homemaker services, respite care, adult day health,

transportation, chore services, companion services, attendant care, adult residential care, and home delivered meals must meet, either by formal training or demonstrated competency, the training requirements contained in the provider training matrix and the standards for direct care staff and allowable tasks or activities in the Department's Aged and Disabled waiver as approved by CMS. (4-4-13)

a. A waiver provider cannot be a relative of any participant to whom the provider is supplying services. (3-19-07)

b. For the purposes of Section 329 of these rules, a relative is defined as a spouse or parent of a minor child. (3-19-07)

c. Individuals who provide direct care or services must satisfactorily complete a criminal history and background check in accordance with IDAPA 16.05.06, "Criminal History and Background Checks." (4-4-13)

04. Quality Assurance. Providers of Aged and Disabled waiver services are responsible for ensuring that they provide quality services in compliance with applicable rules. ( )

a. The results of a quality assurance review conducted by the Department must be transmitted to the provider within forty-five (45) days after the review is completed. ( )

b. The provider must respond to the quality assurance review within forty-five (45) days after the results are received from the Department. If problems are identified, the provider must implement a quality improvement plan and report the results to the Department upon request. ( )

c. *The Department may take enforcement actions as described in IDAPA 16.03.09, "Medicaid Basic Plan Benefits," Section 205, if the provider fails to comply with any term or provision of the provider agreement, or any applicable state or federal regulation.* ( )

05. HCBS *Setting* Compliance. Providers of Aged and Disabled waiver services are responsible for ensuring that they meet the person-centered planning and setting quality requirements described in Sections 311 through 31*8* of these rules, as applicable, and must comply with associated Department quality assurance activities. ( )

0~~4~~6. **Specialized Medical Equipment and Supplies**. Providers of specialized medical equipment and supplies must be enrolled in the Medicaid program as participating medical vendor providers. Providers must ensure all items meet applicable standards of manufacture, design and installation. Preference will be given to equipment and supplies that are the most cost-effective option to meet the participant's needs. (4-4-13)

0~~5~~7. **Skilled Nursing Service**. Skilled nursing service providers must be licensed in Idaho as a registered nurse or licensed practical nurse in good standing, or must be practicing on a federal reservation and be licensed in another state. Skilled nursing providers who provide direct care and services must satisfactorily complete a criminal history and background check in accordance with IDAPA 16.05.06, "Criminal History and Background Checks." (4-4-13)

0~~6~~8. **Consultation Services**. Consultation services must be provided through a Personal Assistance Agency by a person who has demonstrated skills in training participants/family members in hiring, firing, training, and supervising their own care providers. (4-4-13)

0~~7~~9. **Adult Residential Care**. Adult residential care providers will meet all applicable state laws and regulations. In addition, the provider must ensure that adequate staff are provided to meet the needs of the participants accepted for admission. Adult residential care providers who provide direct care or services must satisfactorily complete a criminal history and background check in accordance with IDAPA 16.03.19, "Rules Governing Certified Family Homes," or IDAPA 16.03.22, "Residential Care or Assisted Living Facilities in Idaho." (4-4-13)

10~~8~~. **Home Delivered Meals**. Providers of home delivered meals must be a public agency or private business, and must exercise supervision to ensure that: (4-4-13)

a. Each meal meets one-third (1/3) of the Recommended Daily Allowance, as defined by the Food and Nutrition Board of the National Research Council of the National Academy of Sciences; (4-4-13)

b. Meals are delivered in accordance with the service plan, in a sanitary manner, and at the correct temperature for the specific type of food; (4-4-13)

c. Documentation is maintained demonstrating that the meals served are made from the highest USDA grade for each specific food served; (4-4-13)

d. The agency or business is inspected and licensed as a food establishment under IDAPA 16.02.19, "Food Safety and Sanitation Standards for Food Establishments"; (4-4-13)

e. A Registered Dietitian documents the review and approval of menus, menu cycles, and any changes or substitutions; and (4-4-13)

f. Either by formal training or demonstrated competency, the training requirements contained in the Idaho provider training matrix and the standards for direct care staff in accordance with Subsection 329.03 of this rule have been met. (4-4-13)

0911. **Personal Emergency Response Systems**. Personal emergency response system providers must demonstrate that the devices installed in a waiver participant's home meet Federal Communications Standards, or Underwriter's Laboratory Standards, or equivalent standards. (4-4-13)

1***0***2. **Adult Day Health**. Providers of adult day health must meet the following requirements: (4-4-13)

a. Services provided in a facility must be provided in a facility that meets the building and health standards identified in IDAPA 16.03.21, "Developmental Disabilities Agencies (DDA)." (4-4-13)

b. Services provided in a home must be provided in a home that meets the standards of home certification identified in IDAPA 16.03.19, "Rules Governing Certified Family Homes." (4-4-13)

c. Services provided in a residential adult living facility must be provided in a residential adult living facility that meets the standards identified in IDAPA 16.03.22, "Residential Care or Assisted Living Facilities in Idaho." (4-4-13)

d. Adult day health providers who provide direct care or services must satisfactorily complete a criminal history check in accordance with IDAPA 16.05.06, "Criminal History and Background Checks." (4-4-13)

e. Providers of adult day health must notify the Department on behalf of the participant, if the adult day health is provided in a certified family home other than the participant's primary residence. The adult day health provider must provide care and supervision appropriate to the participant's needs as identified on the plan. (4-4-13)

f. Adult day health providers who provide direct care or services must be free from communicable disease. (4-4-13)

g. All providers of adult day health services must meet, either by formal training or demonstrated competency, the training requirements contained in the Idaho provider training matrix and the standards for direct care staff in accordance with Subsection 329.03 of this rule. (4-4-13)

1***1***3. **Non-Medical Transportation Services**. Providers of non-medical transportation services must: (4-4-13)

a. Possess a valid driver's license; (4-4-13)

b. Possess valid vehicle insurance; and (4-4-13)

c. Meet, either by formal training or demonstrated competency, the training requirements contained in the Idaho provider training matrix and the standards for direct care staff in accordance with Subsection 329.03 of this rule. (4-4-13)

12~~3~~4. Attendant Care. Attendant care providers who provide direct care and services must satisfactorily complete a criminal history and background check in accordance with IDAPA 16.05.06, "Criminal History and Background Checks." All providers of attendant care must meet, either by formal training or demonstrated competency, the training requirements contained in the Idaho provider training matrix and the standards for direct care staff in accordance with Subsection 329.03 of this rule. (4-4-13)

13~~4~~5. Homemaker Services. The homemaker must be an employee of record or fact of an agency. Homemaker service providers who provide direct care or services must satisfactorily complete a criminal history and background check in accordance with IDAPA 16.05.06, "Criminal History and Background Checks." All providers of homemaker services must meet, either by formal training or demonstrated competency, the training requirements contained in the Idaho provider training matrix and the standards for direct care staff in accordance with Subsection 329.03 of this rule. (4-4-13)

14~~5~~6. Environmental Accessibility Adaptations. All services must be provided in accordance with applicable state or local building codes and meet state or local building, plumbing, and electrical requirements for certification. (4-4-13)

15~~6~~7. Residential Habilitation Supported Living. When residential habilitation services are provided by an agency, the agency must be certified by the Department as a residential habilitation agency under IDAPA 16.04.17, "Rules Governing Residential Habilitation Agencies," and supervise the direct services provided. Individuals who provide residential habilitation services in the home of the participant (supported living) must be employed by a residential habilitation agency. Providers of residential habilitation services must meet the following requirements: (4-4-13)

a. Direct service staff must meet the following minimum qualifications: (3-30-07)

i. Be at least eighteen (18) years of age; (3-30-07)

ii. Be a high school graduate, or have a GED, or demonstrate the ability to provide services according to a plan of service; (4-4-13)

iii. Have current CPR and First Aid certifications; (3-30-07)

iv. Be free from communicable disease; (4-4-13)

v. Each staff person assisting with participant medications must successfully complete and follow the "Assistance with Medications" course available through the Idaho Professional Technical Education Program approved by the Idaho State Board of Nursing or other Department-approved training. (3-30-07)

vi. Residential habilitation service providers who provide direct care or services must satisfactorily complete a criminal history and background check in accordance with IDAPA 16.05.06, "Criminal History and Background Checks;" (4-4-13)

vii. Have appropriate certification or licensure if required to perform tasks which require certification or licensure. Direct service staff must also have taken a traumatic brain injury training course approved by the Department. (3-30-07)

b. The provider agency is responsible for providing direct service staff with a traumatic brain injury training course approved by the Department, and training specific to the needs of the participant. (4-4-13)

c. Prior to delivering services to a participant, agency direct service staff must complete an orientation program. The orientation program must include the following subjects: (4-4-13)

i. Purpose and philosophy of services; (3-30-07)

ii. Service rules; (3-30-07)

iii. Policies and procedures; (3-30-07)

iv. Proper conduct in relating to waiver participants; (3-30-07)

v. Handling of confidential and emergency situations that involve the waiver participant; (3-30-07)

vi. Participant rights; (3-30-07)

vii. Methods of supervising participants; (3-30-07)

viii. Working with individuals with traumatic brain injuries; and (3-30-07)

ix. Training specific to the needs of the participant. (3-30-07)

d. Additional training requirements must be completed within six (6) months of employment with the residential habilitation agency and include at a minimum: (3-29-12)

i. Instructional techniques: Methodologies for training in a systematic and effective manner; (3-30-07)

ii. Managing behaviors: Techniques and strategies for teaching adaptive behaviors; (3-30-07)

iii. Feeding; (3-30-07)

iv. Communication; (3-30-07)

v. Mobility; (3-30-07)

vi. Activities of daily living; (3-30-07)

vii. Body mechanics and lifting techniques; (3-30-07)

viii. Housekeeping techniques; and (3-30-07)

ix. Maintenance of a clean, safe, and healthy environment. (3-30-07)

e. The provider agency will be responsible for providing on-going training specific to the needs of the participant as needed. (4-4-13)

168. **Day Habilitation**. Providers of day habilitation services must have a minimum of two (2) years of experience working directly with persons with a traumatic brain injury, must provide documentation of standard licensing specific to their discipline, and must have taken a traumatic brain injury course approved by the Department. Day habilitation providers who provide direct care and services must satisfactorily complete a criminal history and background check in accordance with IDAPA 16.05.06, "Criminal History and Background Checks." (4-4-13)

179. **Respite Care**. Providers of respite care services must meet the following minimum qualifications: (4-4-13)

a. Have received care giving instructions in the needs of the person who will be provided the service; (4-4-13)

b. Demonstrate the ability to provide services according to a plan of service; (4-4-13)

c. Be free of communicable disease; and (4-4-13)

d. Respite care service providers who provide direct care and services must satisfactorily complete a criminal history and background check in accordance with IDAPA 16.05.06, "Criminal History and Background Checks." (4-4-13)

~~18~~20. **Supported Employment**. Supported employment services must be provided by an agency that supervises the direct service and is accredited by the Commission on Accreditation of Rehabilitation Facilities or other comparable standards, or meet State requirements to be a State-approved provider. Supported employment service providers who provide direct care or services must satisfactorily complete a criminal history and background check in accordance with IDAPA 16.05.06, "Criminal History and Background Checks." Providers must also take a traumatic brain injury training course approved by the Department. (4-4-13)

21~~9~~. **Chore Services**. Providers of chore services must meet the following minimum qualifications: (4-4-13)

a. Be skilled in the type of service to be provided; and (4-4-13)

b. Demonstrate the ability to provide services according to a plan of service. (4-4-13)

c. Chore service providers who provide direct care and services must satisfactorily complete a criminal history and background check in accordance with IDAPA 16.05.06, "Criminal History and Background Checks." (4-4-13)

d. Meet, either by formal training or demonstrated competency, the training requirements in the Idaho provider training matrix and the standards for direct care staff in accordance with Subsection 329.03 of this rule. (4-4-13)

(BREAK IN CONTINUITY OF SECTIONS)

508. ADULT DEVELOPMENTAL DISABILITY SERVICES PRIOR AUTHORIZATION: DEFINITIONS.
For the purposes of these rules the following terms are used as defined below. (3-29-12)

01. Adult. A person who is eighteen (18) years of age or older. (3-29-10)

02. Assessment. A process that is described in Section 509 of these rules for program eligibility and in Section 512 of these rules for plan of service. (3-19-07)

03. Clinical Review. A process of professional review that validates the need for continued services. (3-19-07)

04. Community Crisis Support. Intervention for participants who are at risk of losing housing, employment or income, or who are at risk of incarceration, physical harm, family altercations or other emergencies. (3-19-07)

05. Concurrent Review. A clinical review to determine the need for continued prior authorization of services. (3-19-07)

06. Exception Review. A clinical review of a plan that falls outside the established standards. (3-19-07)

07. Interdisciplinary Team. For purposes of these rules, the interdisciplinary team is a team of professionals, determined by the Department, that reviews requests for reconsideration. (3-19-07)

08. Level of Support. An assessment score derived from the SIB-R that indicates types and amounts of services and supports necessary to allow the individual to live independently and safely in the community. (3-19-07)

09. Person-Centered Planning Process. A meeting facilitated by the *participant or* plan developer, comprised of family and individuals significant to the participant who collaborate with the participant to develop the plan of service. ~~(3-19-07)~~( )

10. Person-Centered Planning Team. The group who develops the plan of service. This group includes, at a minimum, the participant and the service coordinator or plan developer chosen by the participant. The person-centered planning team may include others identified by the participant or agreed upon by the participant and the Department as important to the process. (3-19-07)

11. Plan Developer. A paid or non-paid person identified by the participant who is responsible for developing one (1) plan of service and subsequent addenda that cover all services and supports, based on a person-centered planning process. (3-19-07)

12. Plan Monitor. A person who oversees the provision of services on a paid or non-paid basis. (3-19-07)

13. Plan of Service. An initial or annual plan that identifies all services and supports based on a person-centered planning process. Plans are authorized annually every three hundred sixty-five (365) days. (3-19-07)

14. Prior Authorization (PA). A process for determining a participant's eligibility for services and medical necessity prior to the delivery or payment of services as provided by these rules. (3-19-07)

15. Provider Status Review. The written documentation that identifies the participant's progress toward goals defined in the plan of service. (3-19-07)

16. Right Care. Accepted treatment for defined diagnosis, functional needs and abilities to achieve the desired outcome. The right care is consistent with best practice and continuous quality improvement. (3-19-07)

17. Right Place. Services delivered in the most integrated setting in which they normally occur, based on the participant's choice to promote independence. (3-19-07)

18. Right Price. The most integrated and least expensive services that are sufficiently intensive to address the participant's needs. The amount is based on the individual's needs for services and supports as identified in the assessment. (3-19-07)

19. Right Outcomes. Services based on assessed need that ensure the health and safety of the participant and result in progress, maintenance, or delay or prevention of regression for the participant. (3-19-07)

20. Service Coordination. Service coordination is an activity which assists individuals eligible for Medicaid in gaining and coordinating access to necessary care and services appropriate to the needs of an individual. (3-19-07)

21. Service Coordinator. An individual who provides service coordination to a Medicaid-eligible participant, is employed by a service coordination agency, and meets the training, experience, and other requirements under Sections 729 through 732 of these rules. (3-19-07)

22. Services. Services paid for by the Department that enable the individual to reside safely and effectively in the community. (3-19-07)

23. SIB-R. The Scales of Independent Behavior - Revised (SIB-R) is a standardized assessment tool evaluating functional skill levels and evaluating maladaptive behavior. The SIB-R is used by the Department to determine developmental disability eligibility, waiver eligibility, skill level to identify the participant's needs for the plan of service, and for determining the participant budget. (3-19-07)

24. **Supports**. Formal or informal services and activities, not paid for by the Department, that enable the individual to reside safely and effectively in the setting of his choice. (3-19-07)

(BREAK IN CONTINUITY OF SECTIONS)

513. ADULT DEVELOPMENTAL DISABILITY SERVICES PRIOR AUTHORIZATION: PLAN OF SERVICE.
In collaboration with the participant, the Department must assure that the participant has one (1) plan of service. This plan of service is based on the individualized participant budget referred to in Section 514 of these rules and must identify all services and supports. Participants may develop their own plan or designate a paid or non-paid plan developer. In developing the plan of service, the plan developer and the participant must identify services and supports available outside of Medicaid-funded services that can help the participant meet desired goals. Authorized services must be delivered by providers who are selected by the participant. (3-29-12)

01. **Qualifications of a Paid Plan Developer**. Neither a provider of direct service to the participant nor the assessor may be chosen to be the paid plan developer. Family members and all others who wish to be paid for plan development must be employed as a service coordinator as defined in Sections 729 through 732 of these rules. (3-19-07)

02. **Plan Development**. ~~*The plan must be developed with the participant. With the participant's consent, the person-centered planning team*~~ *All participants must direct the development of their service plan through a person-centered planning process.* Individuals invited to participate in the person-centered planning process will be identified by the participant and may include family members, guardian, or individuals who are significant to the participant. In developing the plan of service, the plan developer and participant must identify any services and supports available outside of Medicaid-funded services that can help the participant meet desired goals and outcomes. *( )*

a. The plan of service must be submitted within forty-five (45) days prior to the expiration of the existing plan of service unless delayed because of participant unavailability due to extenuating circumstances. If the plan is not submitted within this time period, authorization for provider payments may be terminated. ~~*(3-19-07)*~~*( )*

b. The plan development process must meet the person-centered planning requirements described in Section 316 of these rules. *( )*

c. *The participant may facilitate his own person-centered planning meeting, or designate a paid or non-paid plan developer to facilitate the meeting. Individuals responsible for facilitating the person-centered planning meeting cannot be providers of direct services to the participant.* *( )*

03. **Prior Authorization Outside of These Rules**. The plan developer must ensure that all services that require prior authorization outside of these rules are submitted to the appropriate unit of the Department. These services include: (3-19-07)

a. Durable Medical Equipment (DME); (3-19-07)

b. Transportation; and (3-19-07)

c. Physical therapy, occupational therapy, and speech-language pathology services. (7-1-13)

04. **No Duplication of Services**. The plan developer will ensure that there is no duplication of services. Duplicate services will not be authorized. (3-29-12)

05. **Plan Monitoring**. The participant, service coordinator or plan monitor must monitor the plan. The

plan developer is the plan monitor unless there is a service coordinator, in which case the service coordinator assumes the roles of both service coordinator and plan monitor. The planning team must identify the frequency of monitoring, which must be at least every ninety (90) days. Plan monitoring must include the following: (3-19-07)

a. Review of the plan of service in a face-to-face contact with the participant to identify the current status of programs and changes if needed; (3-19-07)

b. Contact with service providers to identify barriers to service provision; (3-19-07)

c. Discuss with participant satisfaction regarding quality and quantity of services; and (3-19-07)

d. Review of provider status reviews. (3-29-12)

e. The provider will immediately report all allegations or suspicions of mistreatment, abuse, neglect, or exploitation, as well as injuries of unknown origin to the agency administrator, the Department, the adult protection authority, and any other entity identified under Section 39-5303, Idaho Code, or federal law. (3-29-12)

06. Provider Status Reviews. Service providers, with exceptions identified in Subsection 513.~~11~~09 of these rules, must report the participant's progress toward goals to the plan monitor on the provider status review when the plan has been in effect for six (6) months and at the annual person-centered planning meeting. The semi-annual and annual reviews must include: ~~(3-19-07)~~( )

a. The status of supports and services to identify progress; (3-19-07)

b. Maintenance; or (3-19-07)

c. Delay or prevention of regression. (3-19-07)

07. Content of the Plan of Service. The plan of service must identify the type of service to be delivered, goals to be addressed within the plan year, frequency of supports and services, and identified service providers. The plan of service must include activities to promote progress, maintain functional skills, or delay or prevent regression. (3-19-07)

a. The written plan of service must meet the person-centered planning requirements described in Section 317 of these rules. ( )

b. The written plan of service must be finalized and agreed to according to procedural requirements described in Section 704 of these rules. ( )

c. The Department will distribute a copy of the plan of service to adult DD service providers defined in Section 317 of these rules. Additionally, the plan developer will be responsible to distribute a copy of the plan of service, in whole or part, to any other developmental disability service provider identified by the participant during the person-centered planning process. ( )

08. Informed Consent. Unless the participant has a guardian ~~with appropriate~~ who retains full decision-making authority, the participant must make decisions regarding the type and amount of services required. Prior to plan development, the plan developer must document that they have provided information and support to the participant to maximize their ability to make informed choices regarding the services and supports they receive and from whom. During plan development and amendment, planning team members must each indicate whether they believe the plan meets the needs of the participant, and represents the participant's choice. If ~~not,~~ there is a conflict that cannot be resolved among person-centered planning members or if a member does not believe the plan meets the participant's needs or represents the participant's choice, the plan or amendment ~~must~~ may be referred to the Bureau of ~~Care Management's Medicaid Consumer Relations Specialist~~ Developmental Disability Services to negotiate a resolution with members of the planning team. ~~(3-19-07)~~( )

09. Provider Implementation Plan. Each provider of Medicaid services~~, subject to prior~~

~~*authorization,*~~ must develop an implementation plan that complies with home and community based setting requirements and identifies specific objectives that relate to goals finalized and agreed to in the participant's authorized plan of service. These objectives must demonstrate how the provider will assist the participant to meet the participant's goals, desired outcomes, and needs identified in the plan of service. ~~*(3-19-07)*~~( )

a. Exceptions. An implementation plan is not required for waiver providers of: (3-19-07)

i. Specialized medical equipment; (3-19-07)

ii. Home delivered meals; (3-19-07)

iii. Environmental ~~*modifications*~~ accessibility adaptations; ~~*(3-19-07)*~~( )

iv. Non-medical transportation; (3-19-07)

v. Personal emergency response systems (PERS); (3-19-07)

vi. Respite care; and (3-19-07)

vii. Chore services. (3-19-07)

b. Time for Completion. ~~*The i*~~Implementation plans must be completed within fourteen (14) days ~~*after the initial provision of service, and revised whenever participant needs change*~~ of receipt of the authorized plan of service or the service start date, whichever is later. ~~*(3-19-07)*~~( )

i. If the authorized plan of service is received after the service start date, service providers must support billing by documenting service provision as agreed to by the participant and consistent with Section 704 of these rules. ( )

ii. Implementation plan revision must be based on changes to the needs of the participant. ( )

c. Documentation of Changes. Documentation of Implementation Plan changes will be included in the participant's record. This documentation must include, at a minimum, the reason for the change, documentation of coordination with other service providers (where applicable), the date the change was made, the signature of the person making the change complete with the date and title. (3-19-07)

10. Home and Community Based Services Plan of Service Signature. Upon receipt of the authorized plan of service, HCBS providers responsible for the implementation of the plan as identified in Section 317 of these rules must sign the plan indicating they will deliver services according to the finalized and authorized plan of service, and consistent with home and community based requirements. Each HCBS provider responsible for the implementation of the plan must maintain their signed plan in the participant's record. *Documentation of signature must include the signature of the professional responsible for service provision complete with their title and the date signed.* Provider signature will be completed each time an initial or annual plan of service is implemented. *( )*

1~~0~~1. Addendum to the Plan of Service. *( )*

a. A plan of service may be adjusted during the year with an addendum to the plan. These adjustments must be based on a change to a cost, addition of a service or increase to a service, or a change of provider. Additional assessments or information may be clinically necessary. Adjustment of the plan of service is subject to prior authorization by the Department. ~~*(3-29-12)*~~( )

b. *When a service plan has been adjusted, the Department will distribute a copy of the addendum to HCBS providers responsible for the implementation of the plan of service as identified in Section 317 of these rules.* *( )*

c. Upon receipt of the addendum, the HCBS provider must sign the addendum indicating they have reviewed the plan adjustment and will deliver services accordingly. Documentation must include the signature of the professional responsible for service provision complete with their title and the date signed, and must be maintained in the participant's record. Provider signature will be completed each time an addendum is authorized. ( )

~~*11. Community Crisis Supports. Community crisis supports are interventions for participants who have been determined eligible for developmental disability services and who are at risk of losing housing, employment or income, or are at risk of incarceration, physical harm, family altercation, or other emergencies. Community crisis support may be authorized the following business day after the intervention if there is a documented need for immediate intervention, no other means of support are available, and the services are appropriate to rectify the crisis. Community crisis support is limited to a maximum of twenty (20) hours during any consecutive five (5) day period. (3-19-07)*~~

~~*a. Emergency Room. Crisis services may be provided in an emergency room during the ER evaluation process if the goal is to prevent hospitalization and return the participant to the community. (3-19-07)*~~

~~*b. Before Plan Development. Community crisis support may be provided before or after the completion of the assessment and plan of service. If community crisis support is provided before the completion of the assessment and plan of service, the plan of service must include an identification of the factors contributing to the crisis and a strategy for addressing those factors in the future. (3-19-07)*~~

~~*c. Crisis Resolution Plan. 'After community crisis support has been provided, the provider of the community crisis support service must complete a crisis resolution plan and submit it to the Department for approval within three (3) business days. (3-19-07)*~~

12. Annual Reauthorization of Services. A participant's plan of service must be reauthorized annually. The Department must review and authorize the new plan of service prior to the expiration of the current plan. (3-19-07)

a. Plan Developer Responsibilities for Annual Reauthorization. A new plan of service must be provided to the Department by the plan developer at least forty-five (45) days prior to the expiration date of the current plan. Prior to this, the plan developer must: (3-19-07)

i. Notify the providers who appear on the plan of service of the annual review date. (3-19-07)

ii. Obtain a copy of the current annual provider status review from each provider for use by the person-centered planning team. Each provider status review must meet the requirements in Subsection 513.~~14.d.~~06 of these rules. ~~(3-19-07)~~( )

iii. Convene the person-centered planning team to develop a new plan of service; inviting individuals to participate that have been identified by the participant. ~~(3-19-07)~~( )

b. Evaluation and Prior Authorization of the Plan of Service. The plan of service must be evaluated and prior authorized in accordance with the requirements in Sections 507 and 513 of these rules. (3-19-07)

c. Adjustments to the Annual Budget and Services. The annual budget and services may be adjusted by the Department based on demonstrated outcomes, progress toward goals and objectives, and benefit of services. (3-29-12)

d. Annual Status Reviews Requirement. If the provider's annual status reviews are not submitted with the annual plan, services will not be authorized at the time of the annual reauthorization. These services may be added to the plan of service only by means of an addendum to the plan in accordance with Subsection 513.1~~2~~0 of these rules. ~~(3-19-07)~~( )

e. Reapplication After a Lapse in Service. For participants who are re-applying for service after a lapse in service, the assessor must evaluate whether assessments are current and accurately describe the status of the participant. (3-19-07)

f. Annual Assessment Results. An annual assessment must be completed in accordance with Section 512 of these rules. (3-19-07)

13. Complaints and Administrative Appeals. (3-29-12)

a. Participant complaints about the assessment process, eligibility determination, plan development, quality of service, and other relevant concerns may be referred to the Division of Medicaid. (3-29-12)

b. A participant who disagrees with a Department decision regarding program eligibility and authorization of services under these rules may file an appeal. Administrative appeals are governed by provisions of IDAPA 16.05.03, "Rules Governing Contested Case Proceedings and Declaratory Rulings." (3-29-12)

(BREAK IN CONTINUITY OF SECTIONS)

515. ADULT DEVELOPMENTAL DISABILITY SERVICES: QUALITY ASSURANCE AND IMPROVEMENT.

01. Quality Assurance. Quality Assurance consists of audits and reviews to assure compliance with the Department's rules and regulations. If problems are identified during the review or audit, the provider must implement a corrective action plan within forty-five (45) days after the results are received. The Department may ~~*terminate authorization of service for providers who do not comply with the corrective action plan*~~ take enforcement actions as described in IDAPA 16.03.09, "Medicaid Basic Plan Benefits," Section 205, if the provider fails to comply with the corrective action plan, any term or provision of the provider agreement, or any applicable state or federal regulation. ~~*(3-19-07)*~~( )

02. Quality Improvement. The Department may gather and utilize information from providers to evaluate customer satisfaction, participant satisfaction, participant experience related to home and community based setting qualities, outcomes monitoring, care management, quality assurance, quality improvement activities, and health and safety. These findings may lead to quality improvement activities to improve provider processes and outcomes for participants. ~~*(3-19-07)*~~( )

03. Exception Review. The Department will complete an exception review of plans or addendums requesting services that exceed the assigned budget authorized by the assessor. Requests for these services will be authorized when one (1) of the following conditions are met: (4-11-15)

a. Services are needed to assure the health and safety of participants who require residential high or intense supported living, and the services requested on the plan or addendum are required based on medical necessity as defined in Subsection 012.14 of these rules. (4-11-15)

b. Supported employment services as defined in Section 703 of these rules are needed for the participant to obtain or maintain employment. The request must be submitted on the Department-approved Exception Review Form and is reviewed and approved based on the following: (4-11-15)

i. A supported employment service recommendation must be submitted that includes: recommended amount of service, level of support needed, employment goals, and a transition plan. When the participant is transitioned from the Idaho Division of Vocational Rehabilitation (IDVR) services, the recommendation must be completed by IDVR. When a participant is in an established job, the recommendation must be completed by the supported employment agency identified on the plan of service or addendum; (4-11-15)

ii. The participant's plan of service was developed by the participant and his person-centered planning team and includes a goal for supported employment services. Prior to the submission of an exception review with an addendum, a comprehensive review of all services on the participant's plan must occur. The participant's combination of services must support the increase or addition of supported employment services; and (4-11-15)

iii. An acknowledgement signed by the participant and his legal guardian, if one exists, that additional budget dollars approved to purchase supported employment services must not be reallocated to purchase any other Medicaid service. (4-11-15)

04. Concurrent Review. The Department will obtain the necessary information to determine that participants continue to meet eligibility criteria, *participant rights are maintained* services continue to be clinically necessary, services continue to be the choice of the participant, services support participant integration, and services constitute appropriate care to warrant continued authorization or need for the service. ~~(3-19-07)~~( )

05. Abuse, Fraud, or Substandard Care. Reviewers finding suspected abuse, fraud, or substandard care must refer their findings for investigation to the Department and other regulatory or law enforcement agencies for investigation. (3-19-07)

516. -- 519. (RESERVED)

SUB-PART: CHILDREN'S DEVELOPMENTAL DISABILITIES PRIOR AUTHORIZATION (Sections 520 - 528)

520. CHILDREN'S DEVELOPMENTAL DISABILITY PRIOR AUTHORIZATION (PA).
The purpose of the children's DD Prior Authorization is to ensure the provision of the right care, in the right place, at the right price, and with the right outcomes in order to enhance health and safety, and to promote participants' rights, self-determination, and independence. Prior authorization involves the assessment of the need for services, development of a budget, development of a plan of service, prior approval of services, and a quality improvement program. Prior authorization is intended to *help ensure* the provision of necessary *and* appropriate services and supports. Services are reimbursable if they are identified on the authorized plan of service and are consistent with the purpose and rule for prior authorization as well as rules for HCBS as described in Section 310 through 317 of these rules, and for the specific services included on the plan. *Delivery of each service identified on the plan of service cannot be initiated until after the plan has been signed by the provider agency professional responsible for service provision.* ~~(7-1-11)~~( )

521. CHILDREN'S DEVELOPMENTAL DISABILITY PRIOR AUTHORIZATION (PA): DEFINITIONS.
For the purposes of Sections 520 through 528 of these rules, the following terms are used as defined below. (7-1-11)

01. Assessment. A process that is described in Section 522 of these rules for program eligibility and in Section 526 of these rules for plan of service. (7-1-11)

02. Baseline. A participant's skill level prior to intervention written in measurable, behaviorally-stated terms. (7-1-11)

03. Child. A person who is under the age of eighteen (18) years. (7-1-11)

04. Family. The participant and his parent(s) or legal guardian. (7-1-11)

05. Family-Centered Planning Process. A participant-focused planning process directed by the participant or *the participant's decision-making authority* and facilitated by the *paid or non-paid* plan developer*~~, by which t~~*The family-centered planning team *~~collaborates with the participant to develop~~* discusses the participant's strengths, needs, and *preferences, including the participant's safety and the safety of those around the participant. This discussion* helps the participant *or the participant's decision-making authority* make informed choices *about* the services and supports included on the plan of service. ~~(7-1-11)~~( )

06. Family-Centered Planning Team. The planning group who helps inform the participant about available services *and supports* in order to develop~~s~~ the *participant's* plan of service. This group includes, at a minimum, the child participant ~~*(unless otherwise determined by the family-centered planning team)*~~, the participant's

decision-making authority, and the plan developer. *If the participant is unable to attend the family-centered planning (FCP) meeting, the Plan of Service must contain documentation to justify the participant's absence.* The family-centered planning team ~~*may*~~ must include ~~*others identified by*~~ people chosen by the participant and the family, or agreed upon by the participant and the family ~~*and the Department*~~ as important to the process. ~~*(7-1-11)*~~*( )*

07. ICF/ID. Intermediate care facility for persons with intellectual disabilities. (7-1-11)

08. Individualized Family Service Plan (IFSP). An initial or annual plan of service~~,~~ for providing early intervention services to children from birth to three (3) years of age (thirty-six (36) months old). The plan is developed by the family-centered planning team that includes the child participant, *the participant's decision-making authority and* other planning team members chosen by the *participant's decision-making authority,* and the Department or its designee~~, *for providing early intervention services to children from birth up to three (3) years of age (36 months)*~~. Th~~*is*~~e ~~*plan*~~ IFSP must meet the provisions of the Individuals with Disabilities Education Act (IDEA), Part C, and must be developed in accordance with Sections 316 through 317 of these rules. The IFSP may serve as the plan of service if it meets all of the components of the plan of service. The IFSP may also serve as a program implementation plan. ~~*(7-1-13)*~~*( )*

09. Level of Support. The amount of services and supports necessary to allow the individual to live independently and safely in the community. (7-1-11)

10. Medical, Social, and Developmental Assessment Summary. A form used by the Department to gather a participant's medical, social and developmental history and other summary information. It is required for all participants receiving home and community-based services under a plan of service. The information is used in the assessment and authorization of a participant's services. (7-1-11)

11. Plan Developer. A paid or non-paid person ~~*identified by the participant*~~ who, *under the direction of the participant or the participant's decision-making authority,* is responsible for developing ~~*one (1)*~~ *a single* plan of service and subsequent addenda. *The service plan must* that cover all services and supports ~~*based on a*~~ *identified during the* family-centered planning process and *must* meet the HCBS person-centered plan requirements as described in Section 317 of these rules. ~~*(7-1-11)*~~*( )*

12. Plan Monitor. A person who oversees the provision of services on a paid or non-paid basis and is identified on the participant's person-centered plan of service. ~~*(7-1-11)*~~*( )*

13. Plan of Service. An initial or annual plan of service, developed by the participant, *the participant's decision-making authority,* and the family-centered planning team, that identifies all services and supports ~~*based on that were determined through*~~ a family-centered planning process~~, *and which is*~~. *The plan* develop~~*ed*~~ment *for* ~~*is required in order to*~~ provid~~*ing*~~*e* DD services to children *from* birth through seventeen (17) years of age. This plan must be developed in accordance with Section*s* 316 *and 317* of these rules. ~~*(7-1-11)*~~*( )*

14. Practitioner of the Healing Arts, Licensed. A licensed physician, physician assistant, or nurse practitioner. (7-1-11)

15. Prior Authorization (PA). A process for determining a participant's eligibility for services and medical necessity prior to the delivery or payment of services as provided by Sections 520 and 528 these rules. (7-1-11)

16. Provider Status Review. The written documentation that identifies the participant's progress toward goals defined in the plan of service, and demonstrates the continued need for the service. (7-1-11)

17. Right Care. Accepted treatment for defined diagnosis, functional needs and abilities to achieve the desired outcome. The right care is consistent with best practice and continuous quality improvement. (7-1-11)

18. Right Place. Services delivered in the most integrated setting in which they normally occur, based on the participant's choice to promote independence. (7-1-11)

19. Right Price. The most integrated and least expensive services that are sufficiently intensive to address the participant's needs. The amount is based on the individual's needs for services and supports as identified in the assessment. (7-1-11)

20. Right Outcomes. Services based on assessed need that ensure the health and safety of the participant and result in progress, maintenance, or delay or prevention of regression for the participant. (7-1-11)

21. Services. Evaluation, diagnostic, therapy, training, assistance, and support services that are provided to persons with developmental disabilities. (7-1-11)

(BREAK IN CONTINUITY OF SECTIONS)

524. CHILDREN'S DEVELOPMENTAL DISABILITY PRIOR AUTHORIZATION (PA): COVERAGE AND LIMITATIONS.
The scope of these rules defines prior authorization for the following Medicaid developmental disabilities services for children included in Section 310 of these rules: ~~(7-1-11)~~( )

01. Children's Home and Community Based State Plan Option Services. Children's home and community based state plan option services as described in Sections 660 through 666 of these rules; and (7-1-11)

02. Children's DD Waiver Services. Children's DD waiver services as described in Sections 680 through 686 of these rules. (7-1-11)

525. CHILDREN'S DEVELOPMENTAL DISABILITY PRIOR AUTHORIZATION (PA): PROCEDURAL REQUIREMENTS.
Prior to the development of the plan of service, the plan developer will gather and make referrals for the following information to ~~*guide*~~ facilitate the family-centered planning process: ~~(7-1-11)~~( )

01. Eligibility Determination Documentation. Eligibility determination documentation completed by the Department or its contractor as defined in Subsection 522.03 of these rules. (7-1-11)

02. History and Physical. A current history and physical completed by a practitioner of the healing arts is required at least annually or more frequently as determined by the practitioner. For participants in Healthy Connections, the Healthy Connections physician must conduct the history and physical, and may refer the participant for other evaluations. (7-1-11)

03. Discipline-Specific Assessments. Participants must be referred for an occupational therapy, physical therapy, or speech-language pathology assessment when the participant has a targeted need in one of these disciplines. The assessment is used to guide the provision of services identified on the plan of service. (7-1-11)

04. Additional Information. Gather assessments and information related to the participant's medical conditions, risk of deterioration, living conditions, individual goals, and behavioral or psychiatric needs. (7-1-11)

526. CHILDREN'S DEVELOPMENTAL DISABILITY PRIOR AUTHORIZATION (PA): PLAN OF SERVICE PROCESS.
In collaboration with the participant, the Department must ensure that the participant has one (1) plan of service. This plan of service is developed within the individualized participant budget referred to in Section 527 of these rules and must identify all services and supports. The participant and his parent or legal guardian may develop their own plan or use a paid or non-paid plan developer to assist with plan development. The plan of service must identify services and supports if available outside of Medicaid-funded services that can help the participant meet desired goals. (7-1-11)

01. Plan Development ~~***and Monitoring***~~. Paid plan development ~~*and monitoring*~~ must be provided by the Department or its contractor in accordance with Section 316 of these rules. Non-paid plan development ~~*and*~~

~~monitoring~~ may be provided by the family, or a person of their choosing, in accordance with the Home and Community Based Services (HCBS) regulations in Section 316 of these rules, when this person is not a paid provider of services identified on the child's plan of service. ~~(7-1-11)~~( )

a. *The plan developer is responsible for the documentation of the developed plan and any subsequent plan changes as determined by the family-centered planning team.* ( )

b. *Individuals responsible for facilitating the person-centered planning meeting and developing the plan of service cannot be providers of direct services to the participant.* ( )

02. Plan of Service Development. The plan of service must meet the requirements described in Section 317 of these rules. The service plan must be developed with ~~the parent or legal guardian, and~~ the child participant, ~~(unless otherwise determined by the family-centered planning team)~~ *the participant's decision-making authority,* and facilitated by the Department or its designee. *If the participant is unable to attend the family-centered planning (FCP) meeting, the Plan of Service must contain documentation to justify the participant's absence.* With the ~~parent or legal guardian's~~ *decision-making authority's* consent, the family-centered planning team may include other family members or individuals who are significant to the participant. ~~(7-1-11)~~( )

a. In developing the plan of service, the family-centered planning team must identify any services and supports available outside of Medicaid-funded services that can help the participant meet desired goals. *The development of the service plan must be conducted in accordance with the Home and Community Based Services requirements in Section 317 of these rules.* ~~(7-1-11)~~( )

b. The plan of service must identify, at a minimum, the type of service to be delivered, goals and desired outcomes to be addressed within the plan year, strengths and preferences of the participant, *including the participant's safety and the safety of those around the participant,* target dates, and methods for collaboration. ~~(7-1-11)~~( )

03. No Duplication of Services. The plan developer must ensure that there is no duplication of services. (7-1-11)

04. Plan Monitoring. The family-centered planning team must identify the frequency of monitoring, which must be at least every six (6) months, *and document the plan monitor's name along with the monitoring frequency on the plan*. The plan developer *is considered the plan monitor and* must meet face-to-face with the participant and *the participant's decision-making authority* at least annually. Plan monitoring must include the following: ~~(7-1-11)~~( )

a. Review of the plan of service with the participant and ~~parent or legal guardian~~ *the participant's decision-making authority* to identify the current status of programs and changes if needed; ~~(7-1-11)~~( )

b. *Maintain* ~~C~~*c*ontact with service providers to identify *and remediate* barriers to service provision; ~~(7-1-11)~~( )

c. Discuss with *the* participant and his ~~parent or legal guardian~~ *decision-making authority* their satisfaction regarding quality and quantity of services; and ~~(7-1-11)~~( )

d. Review of provider status reviews *for compliance with the plan of service*. ~~(7-1-11)~~( )

05. Provider Status Reviews. The service providers in Sections 664 and 684 of these rules must report to the plan monitor the participant's progress toward goals. The provider must complete a six (6) month and annual provider status review. The provider status review must be submitted to the plan monitor within forty-five (45) calendar days prior to the expiration of the existing plan of service. (7-1-11)

06. Informed Consent. The participant and ~~his parent or legal guardian~~ *the participant's decision-*

making authority must make decisions regarding the type and amount of services required. *( )*

a. *Prior to plan development, the plan developer must document that they have provided information and support to the participant and the participant's decision-making authority to maximize their ability to make informed choices regarding the services and supports they receive and from whom.* *( )*

b. During plan development and amendments, planning team members must ~~*each indicate*~~ *document* whether they believe the plan is in accordance with the participant's choices of the services and supports identified in the meeting and whether they believe the plan meets the needs of the participant~~, and represents the participant's choice~~. ~~(7-1-11)~~*( )*

c. *If there is a conflict that cannot be resolved among the family-centered planning members or if the participant or the participant's decision-making authority does not believe the plan meets the participant's needs or represents the participant's choice, the plan or amendment may be referred to the Bureau of Developmental Disability Services to negotiate a resolution with the planning team.* *( )*

07. Program Implementation Plan. Providers of children's waiver services listed under Section 684 of these rules must develop an implementation plan that identifies specific objectives that demonstrate how the provider will assist the participant to meet the participant's goals and needs identified in the plan of service. (7-1-13)

a. The implementation plan must be completed within fourteen (14) calendar days after the initial provision of service, and revised whenever participant needs change. (7-1-11)

b. Documentation of implementation plan changes will be included in the participant's record. This documentation must include, at a minimum, the reason for the change, documentation of coordination with other service providers (where applicable), the date the change was made, and the signature of the person making the change complete with his title and the date signed. (7-1-11)

08. Addendum to the Plan of Service. A plan of service may be adjusted during the year with an addendum to the plan. These adjustments must be based on changes in a participant's need or demonstrated outcomes *that result in the need for an addition or reduction of a service, or a change in a provider*. Additional assessments or information may be clinically necessary. Adjustment of the plan of service requires ~~*a parent's or legal guardian's*~~ *the decision-making authority's* signature and ~~*may be subject to*~~ prior authorization by the Department. *The Department will distribute the addendum to the providers involved in the addendum's implementation. Upon receipt by the provider, the addendum must be reviewed, signed, and returned to the Department, with a copy maintained in the participant's record.* ~~(7-1-11)~~*( )*

09. Annual Reauthorization of Services. A participant's plan of service must be reauthorized annually. The Department must review and authorize the new plan of service prior to the expiration of the current plan. (7-1-11)

a. Annual Eligibility Determination Results. An annual determination must be completed in accordance with Section 522 of these rules. (7-1-11)

b. Plan Developer Responsibilities for Annual Reauthorization. A new plan of service must be provided to the Department by the plan developer at least ten (10) calendar days prior to the expiration date of the current plan. Prior to this, the plan developer must: (7-1-13)

i. Notify the providers who appear on the plan of service of the annual review date. (7-1-11)

ii. Obtain a copy of the current annual provider status review from each provider for use by the family-centered planning team. Each provider status review must meet the requirements in Subsection 526.06 of these rules. (7-1-11)

iii. Convene the family-centered planning team to develop a new plan of service. (7-1-11)

c. Evaluation and Prior Authorization of the Plan of Service. The plan of service must be evaluated and prior authorized in accordance with the requirements in Sections 520 and 526 of these rules. (7-1-11)

d. Adjustments to the Annual Budget and Services. The annual budget may be adjusted when there are documented changes that may support placement in a different budget category as identified in Section 527 of these rules. Services may be adjusted at any time during the plan year. (7-1-13)

e. Reapplication After a Lapse in Service. For participants who are re-applying for service after at least a thirty (30) calendar day lapse in service, the assessor must evaluate whether assessments are current and accurately describe the status of the participant. (7-1-11)

(BREAK IN CONTINUITY OF SECTIONS)

528. CHILDREN'S DEVELOPMENTAL DISABILITIES PRIOR AUTHORIZATION (PA): DEPARTMENT'S QUALITY ASSURANCE AND IMPROVEMENT PROCESSES.

01. Quality Assurance. Quality Assurance consists of audits and reviews to ensure compliance with the Department's rules and regulations. If problems are identified during the review or audit, the provider must implement a corrective action plan within forty-five (45) calendar days after the results are received. The Department may terminate authorization of service or the provider agreement for providers who do not comply with the corrective action plan. If the Department finds a provider's deficiency or deficiencies immediately jeopardize the health or safety of its participants, the Department may immediately terminate the provider agreement. (7-1-11)

02. Quality Improvement. The Department may gather and utilize information from participants and providers to evaluate customer satisfaction, participant satisfaction, outcomes monitoring, care management, quality assurance, quality improvement activities, and health and safety. These findings lead to quality improvement activities to improve provider processes and outcomes for participants. (7-1-11)

03. Plan of Service Review. The Department will obtain the necessary information to determine that participants continue to meet eligibility criteria, services continue to be clinically necessary, services continue to be the choice of the participant, and services constitute appropriate care to warrant continued authorization or need for the service. (7-1-11)

04. HCBS Compliance. Providers of children's developmental disability services are responsible for ensuring that they meet the setting quality requirements described in Section 313 of these rules, as applicable, and must comply with associated Department quality assurance activities. The Department may take enforcement actions as described in IDAPA 16.03.09, "Medicaid Basic Plan Benefits," Section 205, if the provider fails to comply with any term or provision of the provider agreement, or any applicable state or federal regulation. ( )

(BREAK IN CONTINUITY OF SECTIONS)

634. -- 648. (RESERVED)

ADULT DEVELOPMENTAL DISABILITIES HOME AND COMMUNITY BASED SERVICES (HCBS) STATE PLAN OPTION (Sections 645 - 659)

645. HOME AND COMMUNITY BASED SERVICES (HCBS) STATE PLAN OPTION.
Home and community based services are provided through the HCBS State Plan option as allowed in Section 1915(i) of the Social Security Act for adults with developmental disabilities who do not meet the ICF/ID level of care. HCBS state plan option services must comply with Sections 310 through 318, and Sections 647 through 659 of these rules. ( )

646. COMMUNITY CRISIS SUPPORTS.
Community crisis supports are interventions for participants who have been determined eligible for developmental disability services and who are at risk of losing housing, employment, or income, or are at risk of incarceration, physical harm, family altercation, or other emergencies. ( )

647. COMMUNITY CRISIS SUPPORTS: ELIGIBILITY.
Prior to receiving community crisis supports, an individual must be determined by the Department or its contractor to have a developmental disability under Sections 500 through 506 of these rules and Section 66-402, Idaho Code, be eighteen (18) years of age or older, and live in the community. ( )

648. COMMUNITY CRISIS SUPPORTS COVERAGE AND LIMITATIONS.
Community crisis support may be authorized the following business day after the intervention if there is a documented need for immediate intervention, no other means of support are available, and the services are appropriate to rectify the crisis. Community crisis support is limited to a maximum of twenty (20) hours during any consecutive five (5) day period. ( )

01. Emergency Room. Crisis services may be provided in an emergency room during the ER evaluation process if the goal is to prevent hospitalization and return the participant to the community. ( )

02. Before Plan Development. Community crisis support may be provided before or after the completion of the assessment and plan of service. If community crisis support is provided before the completion of the assessment and plan of service, the plan of service must include an identification of the factors contributing to the crisis and a strategy for addressing those factors in the future. ( )

03. Crisis Resolution Plan. After community crisis support has been provided, the provider of the community crisis support service must complete a crisis resolution plan and submit it to the Department for approval within *seventy-two (72) hours of providing the service*. ( )

(BREAK IN CONTINUITY OF SECTIONS)

651. DEVELOPMENTAL THERAPY: COVERAGE REQUIREMENTS AND LIMITATIONS.
Developmental therapy must be recommended by a physician or other practitioner of the healing arts. (7-1-13)

01. Requirements to Deliver Developmental Therapy. Developmental therapy may be delivered in a developmental disabilities agency center-based program, the community, or the home of the participant. Participants living in a certified family home must not receive home-based developmental therapy in a certified family home. Developmental therapy includes individual developmental therapy and group developmental therapy. Developmental therapy must be delivered by Developmental Specialists or paraprofessionals qualified in accordance with these rules, based on an assessment completed prior to the delivery of developmental therapy. (7-1-13)

a. Areas of Service. These services must be directed toward the rehabilitation or habilitation of physical or developmental disabilities in the areas of self-care, receptive and expressive language, learning, mobility, self-direction, capacity for independent living, or economic self-sufficiency. (7-1-13)

b. Age-Appropriate. Developmental therapy includes instruction in daily living skills the participant has not gained at the normal developmental stages in his life, or is not likely to develop without training or therapy. Developmental therapy must be age-appropriate. (7-1-11)

c. Tutorial Activities and Educational Tasks are Excluded. Developmental therapy does not include tutorial activities or assistance with educational tasks associated with educational needs that result from the participant's disability. (7-1-11)

d. Settings for Developmental Therapy. Developmental Therapy may be provided in home and community based settings as described in Section 312 of these rules. Developmental therapy, in both individual and

group formats, must be available in both community-based and home-based settings, and be based on participant needs, interests, or choices. ~~(7-1-11)~~( )

e. Staff-to-Participant Ratio. When group developmental therapy is center-based, there must be a minimum of one (1) qualified staff, who may be a paraprofessional or a Developmental Specialist, providing direct services for every twelve (12) participants. The community-based services must occur in integrated, inclusive settings and with no more than three (3) participants per qualified staff at each session. Additional staff must be added, as necessary, to meet the needs of each individual served. (7-1-13)

02. Excluded Services. The following services are excluded for Medicaid payments: (7-1-11)

a. Vocational services; (7-1-11)

b. Educational services; and (7-1-11)

c. Recreational services. (7-1-11)

03. Limitations on Developmental Therapy. Developmental therapy may not exceed the limitations as specified below. (7-1-13)

a. Developmental therapy must not exceed twenty-two (22) hours per week. (7-1-13)

b. Developmental therapy provided in combination with Community Supported Employment services under Subsection 703.04 of these rules, must not exceed forty (40) hours per week. (7-1-13)

c. When a participant receives adult day health as provided in Subsection 703.12 of these rules, the combination of adult day, health and developmental therapy must not exceed thirty (30) hours per week. (7-1-13)

d. Only one (1) type of therapy will be reimbursed during a single time period by the Medicaid program. Developmental therapy will not be reimbursed during periods when the participant is being transported to and from the agency. (7-1-13)

(BREAK IN CONTINUITY OF SECTIONS)

653. DEVELOPMENTAL THERAPY: PROCEDURAL REQUIREMENTS FOR INDIVIDUALS WITH AN IPP.

01. Eligibility Determination. Prior to the delivery of developmental therapy, the person must be determined by the Department or its contractor to be eligible as defined under Section 66-402, Idaho Code, be eighteen (18) years of age or older, and live in the community. (7-1-13)

02. Intake. Individuals using the Home and Community-Based Services (HCBS) waiver for the Aged and Disabled (A&D) or State Plan Personal Care Services and only requesting DDA services, have the option to access services through an Individual Program Plan. Individuals who select this option are not required to have a developmental disability plan developer ~~*or an Individual Service Plan*~~. Services delivered through an Individual Program Plan must be authorized by the Department or its contractor and be based on the Aged and Disabled written Individual Service Plan as defined in Section 328 of these rules. Prior to the delivery of developmental therapy, a DDA must complete an Individual Program Plan (IPP) that meets the standards described below. ~~(7-1-13)~~( )

03. Individual Program Plan (IPP) Definitions. The delivery of developmental therapy on a ~~*plan*~~ written plan of care must be defined in terms of the type, amount, frequency, and duration of the service. ~~(7-1-13)~~( )

a. Type of service refers to the kind of service described in terms of: (7-1-11)

i. Group, individual, or family; and (7-1-11)

ii. Whether the service is home, community, or center-based. (7-1-11)

b. Amount of service is the total number of service hours during a specified period of time. This is typically indicated in hours per week. (7-1-11)

c. Frequency of service is the number of times service is offered during a week or month. (7-1-11)

d. Duration of service is the length of time. This is typically the length of the plan year. For ongoing services, the duration is one (1) year; services that end prior to the end of the plan year must have a specified end date. (7-1-11)

04. Individual Program Plan (IPP). (7-1-13)

a. The IPP must be developed following obtainment or completion of all applicable assessments consistent with the requirements of this chapter. (7-1-11)

b. The planning process must include the participant, his legal guardian if one exists, and others the participant or his legal guardian chooses. The participant and his legal guardian if one exists must sign the IPP indicating ~~*participation in its development*~~ they directed the person-centered planning process. The participant and his legal guardian if one exists must be provided a copy of the completed IPP by the DDA. ~~*If the participant or his legal guardian is unable to participate, the reason must be documented in the participant's record.*~~ A physician or other practitioner of the healing arts, the participant, and his legal guardian if one exists, must sign the IPP prior to initiation of any services identified within the plan. ~~*(7-1-13)*~~( )

c. The planning process must occur at least annually, or more often if necessary, to review and update the plan to reflect any changes in the needs or status of the participant. Revisions to the IPP requiring a change in type, amount, or duration of the service provided must be recommended by the physician or other practitioner of the healing arts prior to implementation of the change. Such recommendations require written authorization by the participant, his legal guardian if one exists, and must be maintained in the participant's file. (7-1-13)

d. The IPP must be supported by the documentation required in the participant's record in accordance with IDAPA 16.03.21, "Developmental Disabilities Agencies (DDA)" record requirements. (7-1-11)

e. The IPP must promote self-sufficiency, the participant's choice in program objectives and activities, encourage the participant's participation and inclusion in the community, and contain objectives that are age-appropriate. The IPP must include: (7-1-11)

i. The participant's name and medical diagnosis; (7-1-11)

ii. The name of the assigned Developmental Specialist, the date of the planning meeting, and the names and titles of those present at the meeting; (7-1-11)

iii. The dated signature of the physician or other practitioner of the healing arts indicating his recommendation of the services on the plan; (7-1-11)

iv. The type, amount, frequency, and duration of therapy to be provided. For developmental therapy, the total hours of services provided cannot exceed the amount recommended on the plan. The amount and frequency of the type of therapy must not deviate from the IPP more than twenty percent (20%) over a period of a four (4) weeks, unless there is documentation of a participant-based reason; (7-1-11)

v. A list of the participant's current personal goals and desired outcomes, interests, and choices; ~~*(7-1-11)*~~( )

vi. An accurate, current, and relevant list of the participant's specific developmental and behavioral strengths and needs. The list will identify which needs are priority based on the participant's choices and preferences.

An IPP objective must be developed for each priority need; (7-1-11)

vii. A list of measurable behaviorally stated objectives, which correspond to the list of priority needs. A Program Implementation Plan must be developed for each objective; (7-1-11)

viii. The Developmental Specialist responsible for each objective; (7-1-13)

ix. The target date for completion of each objective; (7-1-11)

x. The review date; and (7-1-11)

xi. A transition plan. The transition plan is designed to facilitate the participant's independence, personal goals, and interests. The transition plan must specify criteria for participant transition into less restrictive, more integrated settings. These settings may include community-based organizations and activities, vocational training, supported or independent employment, volunteer opportunities, or other less restrictive settings. The implementation of some components of the plan may necessitate decreased hours of service or discontinuation of services from a DDA. (7-1-13)

05. Documentation of Plan Changes. Documentation of required Program Implementation Plan changes must be included in the participant's record. This documentation must include, at a minimum: (7-1-13)

a. The reason for the change; (7-1-11)

b. Documentation of coordination with other services providers, where applicable; (7-1-11)

c. The date the change was made; and (7-1-11)

d. The signature of the professional making the change complete with date, credential, and title. Changes to the IPP require documented notification of the participant and his legal guardian if one exists. Changes in type, amount, or duration of services must be recommended by a physician or other practitioner of the healing arts. Such recommendations require written authorization by the participant and his legal guardian if one exists prior to the change. If the signatures of the participant or his legal guardian cannot be obtained, then the agency must document in the participant's record the reason the signatures were not obtained. (7-1-13)

06. Home and Community Based Person-Centered Planning. Individual Program Plans completed by a DDA must meet the person-centered planning requirements described in Sections 316 and 317 of these rules and must be included in the participant's individual service plan as described in Section 328 of these rules. ( )

654. DEVELOPMENTAL THERAPY: PROCEDURAL REQUIREMENTS.

01. Assessment and Diagnostic Services. DDAs must obtain assessments required under Sections 507 through 515 of these rules. Four (4) hours is the maximum Medicaid reimbursable time allowed for the combination of all assessment, evaluation, or diagnostic services provided in any calendar year. The following assessment and diagnostic services are reimbursable when provided in accordance with these rules: (7-1-13)

a. Comprehensive Developmental Assessment; and (7-1-13)

b. Specific Skill Assessment. (7-1-13)

02. Comprehensive Developmental Assessments. Assessments must be conducted by qualified professionals defined under Section 655 of these rules. (7-1-13)

a. Comprehensive Assessments. A comprehensive assessment must: (7-1-11)

i. Determine the necessity of the service; (7-1-11)

ii. Determine the participant's needs; (7-1-11)

iii. Guide treatment; (7-1-11)

iv. Identify the participant's current and relevant strengths, needs, and interests when these are applicable to the respective discipline; and (7-1-11)

b. Date, Signature, and Credential Requirements. Assessments must be signed and dated by the professional completing the assessment and include the appropriate professional credential or qualification of that person. (7-1-11)

c. Requirements for Current Assessments. Assessments must accurately reflect the current status of the participant. To be considered current, assessments must be completed or updated at least every two (2) years for service areas in which the participant is receiving services on an ongoing basis. (7-1-13)

d. Comprehensive Developmental Assessment. A comprehensive developmental assessment must reflect a person's developmental status in the following areas: (7-1-13)

i. Self-care; (7-1-11)

ii. Receptive and expressive language; (7-1-11)

iii. Learning; (7-1-11)

iv. Gross and fine motor development; (7-1-11)

v. Self-direction; (7-1-11)

vi. Capacity for independent living; and (7-1-11)

vii. Economic self-sufficiency. (7-1-11)

03. Specific Skill Assessments. Specific skill assessments must: (7-1-13)

a. Further assess an area of limitation or deficit identified on a comprehensive assessment. (7-1-13)

b. Be related to a goal on the IPP or ISP. (7-1-13)

c. Be conducted by qualified professionals. (7-1-13)

d. Be conducted for the purposes of determining a participant’s skill level within a specific domain. (7-1-13)

e. Be used to determine baselines and develop the program implementation plan. (7-1-13)

04. DDA Program Documentation Requirements. Each DDA must maintain records for each participant the agency serves. Each participant's record must include documentation of the participant's involvement in and response to the services provided. (7-1-11)

a. General Requirements for Program Documentation. For each participant the following program documentation is required: (7-1-11)

i. Daily entry of all activities conducted toward meeting participant objectives. (7-1-11)

ii. Sufficient progress data to accurately assess the participant's progress toward each objective; and (7-1-11)

iii. A review of the data, and, when indicated, changes in the daily activities or specific implementation

procedures by the qualified professional. The review must include the qualified professional's dated initials. (7-1-11)

iv. Documentation of six (6) month and annual reviews by the Developmental Specialist that includes a written description of the participant's progress toward the achievement of therapeutic goals, and the reason(s) why he continues to need services. (7-1-13)

v. Signed, authorized plan as described in Section 513 of these rules. ( )

b. DDAs must also submit provider status reviews to the plan monitor in accordance with Sections 507 through 515 of these rules. (7-1-13)

05. DDA Program Implementation Plan Requirements. For each participant, the DDA must develop a Program Implementation Plan for each DDA objective included on the participant's required plan of service. All Program Implementation Plans must be related to a goal or objective on the participant's plan of service. The Program Implementation Plan must be ~~*written and implemented*~~ developed within fourteen (14) days ~~*after the first day of ongoing programming*~~ from the plan of service start date or receipt of the authorized plan of service and be revised whenever participant needs change. If the Program Implementation Plan is not completed within this time frame, the participant's records must contain participant-based documentation justifying the delay. If consistent with the timeframes above, a participant's annual Program Implementation Plan is completed after the start date of the annual plan of service, the provider will address goals and objectives as agreed to by the participant until the annual Program Implementation Plan is complete and must document service provision related to these interim goals and objectives consistent with Section 654 of these rules. The Program Implementation Plan must include the following requirements: ~~(7-1-11)~~( )

a. Name. The participant's name. (7-1-11)

b. Baseline Statement. A baseline statement addressing the participant's skill level and abilities related to the specific skill to be learned. (7-1-11)

c. Objectives. Measurable, behaviorally-stated objectives that correspond to those goals or objectives ~~*previously identified on*~~ *authorized* and agreed to in the required plan of service. ~~(7-1-11)~~( )

d. Written Instructions to Staff. These instructions may include curriculum, interventions, task analyses, activity schedules, type and frequency of reinforcement, and data collection including probe, directed at the achievement of each objective. These instructions must be individualized and revised as necessary to promote participant progress toward the stated objective. (7-1-11)

e. Service Environments. Identification of the type of environment(s) where services will be provided. (7-1-11)

f. Target Date. Target date for completion. (7-1-11)

g. Results of the Psychological or Psychiatric Assessment. When a participant has had a psychological or psychiatric assessment, the results of the psychological or psychiatric assessment must be used when developing objectives to ensure therapies provided in the DDA accommodate the participant's mental health needs and to ensure that none of the therapeutic methods are contra-indicated or delivered in a manner that presents a risk to the participant's mental health status. (7-1-11)

h. Home and Community Based Services Requirements. All program implementation plans must meet home and community based setting qualities defined in Section 313 of these rules. ( )

(BREAK IN CONTINUITY OF SECTIONS)

663. CHILDREN'S HCBS STATE PLAN OPTION: COVERAGE AND LIMITATIONS.
All children's home and community based services must be identified on a plan of service developed by the family-

centered planning team, ~~*including the plan developer,*~~ and must be recommended by a physician or other practitioner of the healing arts. The following services are reimbursable when provided in accordance with these rules:
~~(7-1-11)~~( )

01. Respite. Respite provides supervision to the participant on an intermittent or short-term basis because of the need for relief of the primary unpaid caregiver. Respite is available in response to a family emergency or crisis, or may be used on a regular basis to provide relief to the caregiver. Respite may be provided in the participant's home, the private home of the respite provider, a DDA, or in the community. Payment for respite services are not made for room and board. (7-1-11)

a. Respite must only be offered to participants living with an unpaid caregiver who requires relief. (7-1-11)

b. Respite cannot exceed fourteen (14) consecutive days. (7-1-11)

c. Respite must not be provided at the same time other Medicaid services are being provided.(7-1-11)

d. Respite must not be provided on a continuous, long-term basis as a daily service that would enable an unpaid caregiver to work. (7-1-11)

e. The respite provider must not use restraints on participants, other than physical restraints in the case of an emergency. Physical restraints may be used in an emergency to prevent injury to the participant or others, and must be documented in the participant's record. (7-1-11)

f. When respite is provided as group respite, the following applies: (7-1-11)

i. When group respite is center-based, there must be a minimum of one (1) qualified staff providing direct services to every six (6) participants. As the number and severity of the participants with functional impairments or behavioral issues increases, the staff-to-participant ratio must be adjusted accordingly. (7-1-11)

ii. When group respite is community-based, there must be a minimum of one (1) qualified staff providing direct services to every three (3) participants. As the number and severity of the participants with functional impairments or behavioral issues increases, the staff-to-participant ratio must be adjusted accordingly. (7-1-11)

g. Respite cannot be provided as group- or center-based respite when delivered by an independent respite provider. (7-1-11)

h. For Act Early waiver participants, the cost of respite services cannot exceed ten (10) percent of the child's individualized budget amount to ensure the child receives the recommended amount of intervention based on evidence-based research. (7-1-11)

02. Habilitative Supports. Habilitative Supports provides assistance to a participant with a disability by facilitating the participant's independence and integration into the community. This service provides an opportunity for participants to explore their interests, practice skills learned in other therapeutic environments. and learn through interactions in typical community activities. Integration into the community enables participants to expand their skills related to activities of daily living and reinforces skills to achieve or maintain mobility, sensory-motor, communication, socialization, personal care, relationship building, and participation in leisure and community activities. Habilitative Supports must: (7-1-11)

a. Not supplant services provided in school or therapy, or supplant the role of the primary caregiver; (7-1-11)

b. Ensure the participant is involved in age-appropriate activities and is engaging with typical peers according to the ability of the participant; and (7-1-11)

c. Have a minimum of one (1) qualified staff providing direct services to every three (3) participants

when provided as group habilitative supports. As the number and severity of the participants with functional impairments increases, the staff participant ratio shall be adjusted accordingly. (7-1-11)

03. Family Education. Family education is professional assistance to families to help them better meet the needs of the participant. It offers education to the parent or legal guardian that is specific to the individual needs of the family and child as identified on the plan of service. Family education is delivered to families to provide an orientation to developmental disabilities and to educate families on generalized strategies for behavioral modification and intervention techniques specific to their child's diagnoses. (7-1-11)

a. Family education may also provide assistance to the parent or legal guardian in educating other unpaid caregivers regarding the needs of the participant. (7-1-11)

b. The family education providers must maintain documentation of the training in the participant's record documenting the provision of activities outlined in the plan of service. (7-1-11)

c. Family education may be provided in a group setting not to exceed five (5) participants' families. (7-1-11)

04. Family-Directed Community Supports. Families of participants eligible for the children's home and community based state plan option may choose to direct their individualized budget rather than receive the traditional services described in Subsections 663.01 through 663.03 of this rule when the participant lives at home with his parent or legal guardian. The requirements for this option are outlined in IDAPA 16.03.13 "Consumer-Directed Services." (7-1-11)

05. Limitations. (7-1-11)

a. HCBS state plan option services are limited by the participant's individualized budget amount. (7-1-11)

b. For the children's HCBS state plan option services listed in Subsections 663.01, 663.02, and 663.04 of this rule, the following are excluded for Medicaid payment: (7-1-11)

i. Vocational services; and (7-1-11)

ii. Educational services. (7-1-11)

(BREAK IN CONTINUITY OF SECTIONS)

680. CHILDREN'S WAIVER SERVICES.

01. Purpose of and Eligibility for Waiver Services. Under 42 CFR Section 440.180, it is the intention of the Department to provide waiver services to eligible children to prevent unnecessary institutional placement, provide for the greatest degree autonomy and of independence possible, enhance the quality of life, encourage individual choice, and achieve and maintain community integration. For a participant to be eligible, the Department must find that the participant requires services due to a developmental disability that impairs his mental or physical function or independence, is capable of being maintained safely and effectively in a non-institutional setting, and would, in the absence of such services, need to reside in an ICF/ID. ~~(7-1-13)~~( )

02. Waiver Services Provided by a DDA or the Infant Toddler Program. Services provided by a developmental disabilities agency or the Infant Toddler Program to children birth to three (3) years of age must meet the requirements and provisions of the Individuals with Disabilities Education Act (IDEA), Part C; the Family Education Rights and Privacy Act; Sections 16-101, et seq., Idaho Code, regarding early intervention services; and the Idaho State Plan for Early Intervention Services under IDEA, Part C. These requirements include adherence to procedural safeguards and time lines, multi-disciplinary assessments, evaluations, individualized family service plans, provision of early intervention services in the natural environment, transition planning, and enrollment and

reporting requirements. (7-1-13)

(BREAK IN CONTINUITY OF SECTIONS)

683. CHILDREN'S WAIVER SERVICES: COVERAGE AND LIMITATIONS.
All children's DD waiver services must be identified on a plan of service developed by the family-centered planning team, ~~*including the plan developer,*~~ and must be recommended by a physician or other practitioner of the healing arts. In addition to the children's home and community based state plan option services described in Section 663 of these rules, the following services are available for waiver eligible participants and are reimbursable services when provided in accordance with these rules: ~~*(7-1-11)*~~( )

01. Family Training. Family training is professional one-on-one (1 on 1) instruction to families to help them better meet the needs of the waiver participant receiving intervention services. (7-1-11)

a. Family training is limited to training in the implementation of intervention techniques as outlined in the plan of service. (7-1-11)

b. Family training must be provided to the participant's parent or legal guardian when the participant is present. (7-1-11)

c. The family training provider must maintain documentation of the training in the participant's record documenting the provision of activities outlined in the plan of service. (7-1-11)

d. The parent or legal guardian of the waiver participant is required to participate in family training when the participant is receiving habilitative interventions. The following applies for each waiver program: (7-1-11)

i. For participants enrolled in the Children's DD Waiver, the amount, duration, and frequency of the training must be determined by the family-centered planning team and the parent or legal guardian, and must be listed as a service on the plan of service. (7-1-11)

ii. For participants enrolled in the Act Early Waiver, the parent or legal guardian will be required to be present and actively participate during the intervention service session for at least twenty percent (20%) of the intervention time provided to the child. (7-1-11)

02. Interdisciplinary Training. Interdisciplinary training is professional instruction to the direct service provider. Interdisciplinary training must only be provided during the provision of a support or intervention service. Interdisciplinary training is provided to assist the direct provider to meet the needs of the waiver participant. (7-1-11)

a. Interdisciplinary training includes: (7-1-11)

i. Health and medication monitoring; (7-1-11)

ii. Positioning and transfer; (7-1-11)

iii. Intervention techniques; (7-1-11)

iv. Positive Behavior Support; (7-1-11)

v. Use of equipment; (7-1-11)

b. Interdisciplinary training must only be provided to the direct service provider when the participant is present. (7-1-11)

c. The interdisciplinary training provider must maintain documentation of the training in the

participant's record documenting the provision of activities outlined in the plan of service. (7-1-11)

d. Interdisciplinary training between a habilitative interventionist and a therapeutic consultant is not a reimbursable service. (7-1-11)

e. Interdisciplinary training between employees of the same discipline is not a reimbursable service. (7-1-11)

03. Habilitative Intervention Evaluation. The purpose of the habilitative intervention evaluation is to guide the formation of developmentally-appropriate objectives and intervention strategies related to goals identified through the family-centered planning process. The habilitative interventionist must complete an evaluation prior to the initial provision of habilitative intervention services. The evaluation must include: (7-1-11)

a. Specific skills assessments for deficit areas identified through the eligibility assessment; (7-1-11)

b. Functional behavioral analysis; (7-1-11)

c. Review of all assessments and relevant histories provided by the plan developer; and (7-1-11)

d. Clinical Opinion. Professional summary that interprets and integrates the results of the testing. This summary includes functional, developmentally appropriate recommendations to guide treatment. (7-1-11)

04. Habilitative Intervention. Habilitative intervention services must be consistent, aggressive, and continuous and are provided to improve a child's functional skills and minimize problem behavior. Services include individual or group behavioral interventions and skill development activity. Habilitative intervention must be based upon the well-known and widely regarded principles of evidence-based treatment. Evidence-based treatment (EBT) refers to the use of mental and behavioral health interventions for which systematic empirical research has provided evidence of statistically significant effectiveness as treatments for specific problems. As "promising practices" meet statistically significant effectiveness, they could be included as approved approaches. (7-1-11)

a. Habilitative intervention must be provided to meet the intervention needs of the participant by developing adaptive skills for all participants, and addressing maladaptive behaviors for participants who exhibit them. (7-1-11)

i. When goals to address maladaptive behavior are identified on the plan of service, the intervention must include the development of replacement behavior rather than merely the elimination or suppression of maladaptive behavior that interferes with the child's overall general development, community, and social participation. (7-1-11)

ii. When goals to address skill development are identified on the plan of service, the intervention must provide for the acquisition of skills that are functional. (7-1-11)

b. Habilitative intervention must be provided in the participant's home or community setting, and in addition may be provided in a center-based setting. (7-1-11)

c. Group intervention may be provided in the community and center. When habilitative intervention is provided as group intervention, the following applies: (7-1-11)

i. There must be a minimum of one (1) qualified staff providing direct services for every three (3) participants. As the number and severity of the participants with functional impairments or behavioral issues increases, the staff participant ratio must be adjusted accordingly. (7-1-11)

ii. When group intervention is community-based, the child must be integrated in the community in a natural setting with typically developing peers. (7-1-11)

iii. Group intervention must be directly related to meeting the needs of the child, and be identified as an objective in accordance with a plan of service goal. (7-1-11)

05. Therapeutic Consultation. Therapeutic consultation provides a higher level of expertise and experience to support participants who exhibit severe aggression, self-injury, and other dangerous behaviors. Therapeutic consultation is provided when a participant receiving habilitative intervention has been assessed as requiring a more advanced level of training and assistance based on the participant's complex needs. A participant requires therapeutic consultation when interventions are not demonstrating outcomes and it is anticipated that a crisis event may occur without the consultation service. (7-1-11)

a. The therapeutic consultant assists the habilitative interventionist by: (7-1-11)

i. Performing advanced assessments as necessary; (7-1-11)

ii. Developing and overseeing the implementation of a positive behavior support plan; (7-1-11)

iii. Monitoring the progress and coordinating the implementation of the positive behavioral support plan across environments; and (7-1-11)

iv. Providing consultation to other service providers and families. (7-1-11)

b. Telehealth resources may be used by a therapeutic consultant to provide consultation as appropriate and necessary. (7-1-11)

c. Therapeutic consultation providers are subject to the following limitations: (7-1-11)

i. Therapeutic consultation cannot be provided as a direct intervention service. (7-1-11)

ii. Participants must be receiving habilitative intervention services prior to accessing therapeutic consultation, with the exception of crisis situations. (7-1-11)

iii. Therapeutic consultation is limited to eighteen (18) hours per year per participant. (7-1-11)

iv. Therapeutic consultation must be prior authorized by the Department. (7-1-11)

06. Crisis Intervention. Crisis intervention services provide direct consultation and clinical evaluation of participants who are currently experiencing or may be expected to experience a psychological, behavioral, or emotional crisis. The need for crisis intervention must meet the definition of crisis in Section 681 of these rules. This service may provide training and staff development related to the needs of a participant, and also provides emergency back-up involving the direct support of the participant in crisis. Children's crisis intervention services: (7-1-11)

a. Are provided in the home and community. (7-1-11)

b. Are provided on a short-term basis typically not to exceed thirty (30) days. (7-1-11)

c. Cannot exceed fourteen (14) days of out-of-home placement. (7-1-11)

d. Must be prior authorized by the Department. (7-1-11)

i. Authorization for crisis intervention may be requested retroactively as a result of a crisis, defined in Section 681 of these rules, when no other means of support is available to the participant. In retroactive authorizations, the crisis intervention provider must submit a request for crisis intervention to the Department within seventy-two (72) hours of providing the service. (7-1-11)

ii. If staying in the home endangers the health and safety of the participant, the family, or both, the provider may request short-term out of home placement for the participant. Out of home placement must be prior authorized by the Department. (7-1-11)

e. Must use positive behavior interventions prior to and in conjunction with the implementation of

any restrictive intervention. (7-1-11)

f. Telehealth resources may be used by a crisis interventionist to provide consultation in a crisis situation. (7-1-11)

07. Family-Directed Community Supports. Families of participants eligible for the children's DD waiver may choose to direct their individualized budget rather than receive the traditional services described in Subsections 683.01 through 683.06 of this rule when the participant lives at home with the parent or legal guardian. The requirements for selecting and participating in this option are outlined in IDAPA 16.03.13 "Consumer Directed Services." Act Early Waiver participants do not have the option to choose the family-directed services path. The Act Early Waiver is intended to be a more structured program that requires increased involvement from families, and ensures children receive an intense amount of services based on evidence-based research. (7-1-11)

08. Service limitations. Children's waiver services are subject to the following limitations: (7-1-11)

a. Place of Service Delivery. Waiver services may be provided in the participant's personal residence, community, or DDA. The following living situations are specifically excluded as a place of service for waiver services: (7-1-11)

i. Licensed skilled or intermediate care facilities, certified nursing facility (NF) or hospital; and (7-1-11)

ii. Licensed Intermediate Care Facility for persons with Intellectual Disabilities (ICF/ID); and (7-1-11)

iii. Residential Care or Assisted Living Facility; (7-1-11)

iv. Additional limitations to specific services are listed under that service definition. (7-1-11)

b. According to 42 CFR 440.180, Medicaid Waiver services cannot be used to pay for special education and related services that are included in a child's Individual Educational Plan (IEP) under the provisions of Individuals with Disabilities Education Improvement Act of 2004 (IDEA), that are otherwise available through a local educational agency. (7-1-11)

c. Children's waiver services are limited by the participant's individualized budget amount, excluding crisis intervention. (7-1-11)

d. For the children's waiver services listed in Subsections 683.01 through 683.07 of these rules, the following are excluded for Medicaid payment: (7-1-11)

i. Vocational services; (7-1-11)

ii. Educational services; and (7-1-11)

iii. Recreational services. (7-1-11)

(BREAK IN CONTINUITY OF SECTIONS)

703. ADULT DD WAIVER SERVICES: COVERAGE AND LIMITATIONS.

01. Residential Habilitation. Residential habilitation services consist of an integrated array of individually tailored services and supports furnished to eligible participants. These services and supports are designed to assist the participants to reside successfully in their own homes, with their families, or in certified family homes. The services and supports that may be furnished consist of the following: (4-4-13)

a. Habilitation services aimed at assisting the individual to acquire, retain, or improve his ability to reside as independently as possible in the community or maintain family unity. Habilitation services include training in one (1) or more of the following areas: (3-19-07)

i. Self-direction, including the identification of and response to dangerous or threatening situations, making decisions and choices affecting the individual's life, and initiating changes in living arrangements or life activities; (3-19-07)

ii. Money management including training or assistance in handling personal finances, making purchases, and meeting personal financial obligations; (3-19-07)

iii. Daily living skills including training in accomplishing routine housekeeping tasks, meal preparation, dressing, personal hygiene, self-administration of medications, and other areas of daily living including proper use of adaptive and assistive devices, appliances, home safety, first aid, and emergency procedures; (3-19-07)

iv. Socialization including training or assistance in participation in general community activities and establishing relationships with peers with an emphasis on connecting the participant to his community. (Socialization training associated with participation in community activities includes assisting the participant to identify activities of interest, working out arrangements to participate in such activities and identifying specific training activities necessary to assist the participant to continue to participate in such activities on an on-going basis. Socialization training does not include participation in non-therapeutic activities which are merely diversional or recreational in nature); (3-19-07)

v. Mobility, including training or assistance aimed at enhancing movement within the person's living arrangement, mastering the use of adaptive aids and equipment, accessing and using public transportation, independent travel, or movement within the community; (3-19-07)

vi. Behavior shaping and management includes training and assistance in appropriate expressions of emotions or desires, assertiveness, acquisition of socially appropriate behaviors; or extension of therapeutic services, which consist of reinforcing physical, occupational, speech and other therapeutic programs. (3-19-07)

b. Personal Assistance Services necessary to assist the individual in daily living activities, household tasks, and such other routine activities as the participant or the participant's primary caregiver(s) are unable to accomplish on his own behalf. (3-19-07)

c. Skills training to teach waiver participants, family members, alternative family caregiver(s), or a participant's roommate or neighbor to perform activities with greater independence and to carry out or reinforce habilitation training. Services are focused on training and are not designed to provide substitute task performance. Skills training is provided to encourage and accelerate development in independent daily living skills, self-direction, money management, socialization, mobility and other therapeutic programs. (3-19-07)

02. Chore Services. Chore services include the following services when necessary to maintain the functional use of the home or to provide a clean, sanitary, and safe environment. (4-4-13)

a. Intermittent Assistance may include the following: (4-4-13)

i. Yard maintenance; (4-4-13)

ii. Minor home repair; (4-4-13)

iii. Heavy housework; (4-4-13)

iv. Sidewalk maintenance; and (4-4-13)

v. Trash removal to assist the participant to remain in the home. (4-4-13)

b. Chore activities may include the following: (4-4-13)

i. Washing windows; (4-4-13)

ii. Moving heavy furniture; (4-4-13)

iii. Shoveling snow to provide safe access inside and outside the home; (4-4-13)

iv. Chopping wood when wood is the participant's primary source of heat; and (4-4-13)

v. Tacking down loose rugs and flooring. (4-4-13)

c. These services are only available when neither the participant, nor anyone else in the household, is capable of performing or financially providing for them, and where no other relative, caregiver, landlord, community volunteer, agency, or third-party payer is willing to provide them, or is responsible for their provision. (4-4-13)

d. In the case of rental property, the landlord's responsibility under the lease agreement will be examined prior to any authorization of service. Chore services are limited to the services provided in a home rented or owned by the participant. (4-4-13)

03. Respite Care. Respite care includes short-term breaks from care giving responsibilities to non-paid caregivers. The caregiver or participant is responsible for selecting, training, and directing the provider. While receiving respite care services, the waiver participant cannot receive other services that are duplicative in nature. Respite care services provided under this waiver do not include room and board payments. Respite care services may be provided in the participant's residence, the private home of the respite provider, the community, a developmental disabilities agency, or an adult day health facility. (4-4-13)

04. Supported Employment. Supported employment consists of competitive work in integrated work settings for individuals with the most severe disabilities for whom competitive employment has not traditionally occurred; or for whom competitive employment has been interrupted or intermittent as a result of a severe disability. Because of the nature and severity of their disability, these individuals need intensive supported employment services or extended services in order to perform such work. (4-4-13)

a. Supported employment services rendered under the waiver are not available under a program funded by either the Rehabilitation Act of 1973, as amended, or the Individuals with Disabilities Education Act (IDEA). Documentation must be maintained in the file of each individual receiving this service verifying that the service is not otherwise available or funded under the Rehabilitation Act of 1973 as amended, or the IDEA. (4-4-13)

b. Federal Financial Participation (FFP) cannot be claimed for incentive payments, subsidies, or unrelated vocational training expenses such as the following: incentive payments made to an employer of waiver participants to encourage or subsidize the employers' participation in a supported employment program; payments that are passed through to beneficiaries of supported employment programs; or payments for vocational training that are not directly related to a waiver participant's supported employment program. (4-4-13)

05. Non-Medical Transportation. Non-medical transportation enables a waiver participant to gain access to waiver and other community services and resources. (4-4-13)

a. Non-medical transportation is offered in addition to medical transportation required in IDAPA 16.03.09, "Medicaid Basic Plan Benefits," and will not replace it. (4-4-13)

b. Whenever possible, family, neighbors, friends, or community agencies who can provide this service without charge or public transit providers will be utilized. (4-4-13)

06. Environmental Accessibility Adaptations. Environmental accessibility adaptations include minor housing adaptations that are necessary to enable the participant to function with greater independence in the home, or without which, the participant would require institutionalization or have a risk to health, welfare, or safety. Such adaptations may include: (4-4-13)

a. The installation of ramps and lifts, widening of doorways, modification of bathroom facilities, or installation of electric and plumbing systems that are necessary to accommodate the medical equipment and supplies necessary for the welfare of the waiver participant, but must exclude those adaptations or improvements to the home that are not of direct medical or remedial benefit to the participant, such as carpeting, roof repair, or central air conditioning. (4-4-13)

b. Unless otherwise authorized by the Department, permanent environmental modifications are limited to a home that is the participant's principal residence, and is owned by the participant or the participant's non-paid family. (4-4-13)

c. Portable or non-stationary modifications may be made when such modifications can follow the participant to his next place of residence or be returned to the Department. (4-4-13)

07. Specialized Medical Equipment and Supplies. (4-4-13)

a. Specialized medical equipment and supplies include: (4-4-13)

i. Devices, controls, or appliances that enable a participant to increase his abilities to perform activities of daily living, or to perceive, control, or communicate with the environment in which he lives; and (4-4-13)

ii. Items necessary for life support, ancillary supplies and equipment necessary for the proper functioning of such items, and durable and non-durable medical equipment not available under the Medicaid State Plan. (4-4-13)

b. Items reimbursed with waiver funds are in addition to any medical equipment and supplies furnished under the Medicaid State Plan and exclude those items that are not of direct medical or remedial benefit to the participant. (4-4-13)

08. Personal Emergency Response System (PERS). PERS is an electronic device that enables a waiver participant to secure help in an emergency. The participant may also wear a portable "help" button to allow for mobility. The system is connected to the participant's phone and programmed to signal a response center once a "help" button is activated. The response center is staffed by trained professionals. This service is limited to participants who: (4-4-13)

a. Rent or own a home, or live with unpaid caregivers; (4-4-13)

b. Are alone for significant parts of the day; (4-4-13)

c. Have no caregiver for extended periods of time; and (4-4-13)

d. Would otherwise require extensive, routine supervision. (4-4-13)

09. Home Delivered Meals. Home delivered meals are meals that are delivered to a participant's home to promote adequate participant nutrition. One (1) to two (2) meals per day may be provided to a participant who: (4-4-13)

a. Rents or owns a home; (4-4-13)

b. Is alone for significant parts of the day; (4-4-13)

c. Has no caregiver for extended periods of time; and (4-4-13)

d. Is unable to prepare a meal without assistance. (4-4-13)

10. Skilled Nursing. Skilled nursing includes intermittent or continuous oversight, training, or skilled care that is within the scope of the Nurse Practice Act. Such care must be provided by a licensed registered nurse, or

licensed practical nurse, under the supervision of a registered nurse licensed to practice in Idaho. (4-4-13)

11. Behavior Consultation/Crisis Management. Behavior Consultation/Crisis Management services which provide direct consultation and clinical evaluation of participants who are currently experiencing or may be expected to experience, a psychological, behavioral, or emotional crisis. This service may provide training and staff development related to the needs of a participant. These services also provide emergency back-up involving the direct support of the participant in crisis. (3-19-07)

12. Adult Day Health. Adult day health is a supervised, structured service generally furnished four (4) or more hours per day on a regularly scheduled basis, for one (1) or more days per week. It is provided outside the home of the participant in a non-institutional, community-based setting, and it encompasses health services, social services, recreation, supervision for safety, and assistance with activities of daily living needed to ensure the optimal functioning of the participant. Adult day health services provided under this waiver will not include room and board payments. Adult day health cannot exceed thirty (30) hours per week, either alone or in combination with developmental therapy and occupational therapy. (4-4-13)

13. Self-Directed Community Supports. Participants eligible for the DD Waiver may choose to self-direct their individualized budget rather than receive the traditional waiver services described in this section of rule. The requirements for this option are outlined in IDAPA 16.03.13, "Consumer Directed Services." (3-19-07)

14. Place of Service Delivery. Waiver services may be provided in home and community settings as described in Section 312 of these rules. Approved places of services include the participant's personal residence, a certified family home, day habilitation/supported employment program, or community. The following living situations are specifically excluded as a place of service for waiver services: ~~(3-19-07)~~( )

a. Licensed skilled, or intermediate care facilities, certified nursing facility (NF) or hospital; and (3-19-07)

b. Licensed Intermediate Care Facility for Persons with Intellectual Disabilities (ICF/ID); and (3-19-07)

c. Residential Care or Assisted Living Facility. (3-19-07)

d. Additional limitations to specific services are listed under that service definition. (3-19-07)

(BREAK IN CONTINUITY OF SECTIONS)

723. TARGETED SERVICE COORDINATION: ELIGIBILITY: INDIVIDUALS WITH A DEVELOPMENTAL DISABILITY.
An individual is eligible to receive targeted service coordination if he meets the following requirements in Subsection 723.01 through 723.03 of this rule. ~~(5-8-09)~~( )

01. Age. An adult eighteen (18) years of age or older. (3-29-10)

02. Diagnosis. Is diagnosed with a developmental disability, defined in Section 66-402, Idaho Code and Section 500 through 506 of these rules, that: (5-8-09)

a. Is attributable to an impairment, such as an intellectual disability, cerebral palsy, epilepsy, autism or other condition found to be closely related to or similar to one (1) of these impairments that requires similar treatment or services, or is attributable to dyslexia resulting from such impairments; (5-8-09)

b. Results in substantial functional limitations in three (3) or more of the following areas of major life activity: self-care, receptive and expressive language, learning, mobility, self-direction, capacity for independent living, or economic self-sufficiency; and (3-19-07)

c. Reflects the need for a combination and sequence of special, interdisciplinary or generic care, treatment or other services which are of lifelong or extended duration and individually planned and coordinated. (5-8-09)

03. Need Assistance. Requires and chooses assistance to access services and supports necessary to maintain his independence in the community. (5-8-09)

(BREAK IN CONTINUITY OF SECTIONS)

727. SERVICE COORDINATION: COVERAGE AND LIMITATIONS.
Service coordination consists of services provided to assist individuals in gaining access to needed services. Service coordination includes the following activities described in Subsections 727.01 through 727.10 of this rule. (3-20-14)

01. Plan Assessment and Periodic Reassessment. Activities that are required to determine the participant's needs by development of a plan assessment and periodic reassessment as described in Section 730 of these rules. These activities include: (5-8-09)

a. Taking a participant's history; (5-8-09)

b. Identifying the participant's needs and completing related documentation; and (5-8-09)

c. Gathering information from other sources such as family members, medical providers, social workers, and educators, to form a complete assessment of the participant. (5-8-09)

02. Development of the Plan. Development and revision of a specific plan, described in Section 731 of these rules that includes information collected through the assessment and specifies goals and actions needed by the participant. The plan must be updated at least annually and as needed to meet the needs of the participant. (3-20-14)

03. Referral and Related Activities. Activities that help link the participant with service providers that are capable of providing needed services to address identified needs and achieve goals specified in the service coordination plan. (3-20-14)

04. Monitoring and Follow-Up Activities. Monitoring and follow-up contacts that are necessary to ensure the plan is implemented and adequately addresses the participant's needs. These activities may be with the participant, family members, providers, or other entities or individuals and conducted as frequently as necessary. These activities must include at least one face-to-face contact with the participant at least every ninety (90) days, to determine whether the following conditions are met: (5-8-09)

a. Services are being provided according to the participant's plan; (5-8-09)

b. Services in the plan are adequate; and (5-8-09)

c. Whether there are changes in the needs or status of the participant, and if so, making necessary adjustments in the plan and service arrangements with providers. (5-8-09)

05. Crisis Assistance. Crisis assistance is service coordination used to assist a participant to access community resources in order to resolve a crisis. Crisis service coordination does not include crisis counseling, transportation to emergency service providers, or direct skill-building services. The need for all crisis assistance hours must meet the definition of crisis in Section 721 of these rules. (5-8-09)

a. Crisis Assistance for Children's Service Coordination. Crisis hours are not available until four and a half (4.5) hours of service coordination have already been provided in the month. Crisis hours for children's service coordination must be authorized by the Department. (5-8-09)

b. Crisis Assistance for Adults With a Developmental Disability. Crisis hours are not available until four and a half (4.5) hours of service coordination have already been provided in the month. Crisis assistance for adults with a developmental disability must be authorized by the Department and is based on community crisis supports as found in Section ~~*507*~~ 646 through ~~*515*~~ 648 of these rules. ~~*(5-8-09)*~~( )

c. Authorization for crisis assistance hours may be requested retroactively as a result of a crisis, defined in Section 721 of these rules, when a participant's service coordination benefits have been exhausted and no other means of support is available to the participant. In retroactive authorizations, the service coordinator must submit a request for crisis services to the Department within seventy-two (72) hours of providing the service. (5-8-09)

06. Contacts for Assistance. Service coordination may include contacts with non-eligible individuals only when the contact is directly related to identifying the needs and supports to help the participant access services. (5-8-09)

07. Exclusions. Service coordination does not include activities that are: (5-8-09)

a. An integral component of another covered Medicaid service; (5-8-09)

b. Integral to the administration of foster care programs; (5-8-09)

c. Integral to the administration of another non-medical program for which a participant may be eligible. This exclusion does not apply to case management provided as part of the individualized education program or individualized family service plan required by the Individuals with Disabilities Education Act. (5-8-09)

08. Limitations on the Provision of Direct Services. Providers of service coordination services may only provide both service coordination and direct services to the same Medicaid participant when the participant is receiving children's service coordination. The service coordination provider must document that the participant has made a free choice of service coordinators and direct service providers. (3-20-14)

09. Limitations on Service Coordination. Service coordination is limited to four and a half (4.5) hours per month. (3-20-14)

10. Limitations on Service Coordination Plan Assessment and Plan Development. Reimbursement for the annual assessment and plan development cannot exceed six (6) hours per year. (3-20-14)

(BREAK IN CONTINUITY OF SECTIONS)

731. SERVICE COORDINATION: PLAN DEVELOPMENT -- WRITTEN PLAN.
The service coordination plan is developed using information collected through the assessment of the participant's service coordination needs. The plan must specify the goals and actions to address the service coordination needs of the participant identified in the assessment process. The plan must include goals developed using the person-centered planning process. (5-8-09)

01. Plan Implementation. The plan must identify activities required to respond to the assessed needs of the participant. (5-8-09)

02. Plan Content. Plans must include the following: (5-8-09)

a. A list of problems and needs identified during the assessment; (5-8-09)

b. Identification of each and any potential risk or substantiation that there are no potential risks. The plan must identify services and actions that will be implemented in case of a participant crisis situation. (5-8-09)

c. Concrete, measurable goals and objectives to be achieved by the participant; (5-8-09)

d. Reference to all services and contributions provided by the participant's supports including the actions, if any, taken by the service coordinator to develop the support system; (5-8-09)

e. Documentation of who has been involved in the service planning, including the participant's involvement; (5-8-09)

f. Schedules for service coordination monitoring, progress review, and reassessment; (5-8-09)

g. Documentation of unmet needs and service gaps including goals to address these needs or gaps; (5-8-09)

h. References to any formal services arranged including costs, specific providers, schedules of service initiation, frequency or anticipated dates of delivery; and (5-8-09)

i. Time frames for achievement of the goals and objectives. (5-8-09)

03. Adult Developmental Disability Service Coordination Plan. The plan for adults with developmental disabilities must comply with and be incorporated into the participant's developmental disability plan of service identified in Section 513 of these rules. ~~(5-8-09)~~( )